Supreme Court, U.S.
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No. 96-

In The
Supreme Court of the United States
October Term, 1996

State of Louisiana, ex rel. RICHARD P. IEYOUB,
Attorney General
Petitioner

v.

CIGNA Health Plan of Louisiana, Inc. and
Connecticut General Life Insurance Co.
Respondents

On Petition for Writ of Certiorari to the United States Fifth Circuit Court of Appeals

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PETITION FOR WRIT OF CERTIORARI

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84 pp

QUESTIONS PRESENTED FOR REVIEW

1. Was it the *intent* of Congress in enacting the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. 1001 et seq., to prohibit states from including an "any willing provider" provision in a preferred provider organization enabling statute, when the state health care statute does not relate to ERISA plans, does not impinge upon the objectives of ERISA by mandating employee benefit structures or benefits in the sense required for pre-emption, does not provide alternate enforcement mechanisms, does not operate to "effectively restrict' the choice of policies available in the market, is not predicated upon the existence of ERISA plans, does not single out ERISA plans for special treatment, and *may* affect them only in an indirect economic manner, but rather, does regulate a contractual agreement to provide health care services *(insurance)* between health care providers and group purchasers of health care services, which may be utilized by ERISA plans, by providing that no licensed provider who agrees to the terms of the contract shall be denied the right to become a preferred provider.

2. May a citizen of another state doing business within the state use the judicially created exception to the states' Eleventh Amendment immunity of *Ex parte Young* to sue a state in its own name through its attorney general in federal court to enjoin a civil statute, not unconstitutional on its face, to declare a section of the statute unconstitutional and enjoining the state officer from enforcing it, thereby nullifying the state's significant constitutional guaranty by alleging ERISA preemption of a civil health care statute, using the Fifth Circuit's own judicially created legal rule that *regardless* of the strong legal presumption against preemption, a federal court *always* has jurisdiction to determine if state officers are violating federal law, when this Court has held previously that health care regulation statutes do not relate to ERISA plans and thus, do not need to be "saved" from preemption, when the *Ex parte Young* Court itself, held such action to be *inconsistent with the Constitution*, when this Court has previously ruled that suits against an officer of the state in his official capacity are suits against the state itself, *and* when this Court has

recently held that even when the Constitution vests in Congress complete law-making authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States.

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the decision of the United States Court of Appeals for the Fifth Circuit, which is contained in the appendix at pages 3a-15a.

In accordance with Supreme Court Rule 29.1, Petitioner State of Louisiana, through its Attorney General, states that it does not have a corporate parent or subsidiaries.

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In The
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State of Louisiana, ex rel. RICHARD P. IEYOUB,
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Appealed from the United States Fifth Circuit Court of Appeals

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PETITION FOR WRIT OF CERTIORARI

Petitioner State of Louisiana, through its Attorney General, respectfully petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals for the Fifth Circuit is reported at 82 F.3d 642. It is reproduced in the appendix at 3a to 15a. The decision of the United States District Court for the Eastern District of Louisiana is reported at 883 F. Supp. 94. It is also reproduced in the appendix at 17a to 35a.

JURISDICTION

The judgment of the Court of Appeals was initially entered on April 30, 1996. On May 13, 1996, a petition for rehearing was filed. On June 4, 1996, the petition for rehearing was denied. That order is reproduced in the appendix at 1a. Pursuant to Rule

13 of the Rules of the Supreme Court of the United States, this petition is timely filed within ninety (90) days of the date of the denial of rehearing, which time ends on September 3, 1996. This Court has jurisdiction pursuant to 28 U.S. C. 1254(1).

STATUTORY PROVISIONS INVOLVED

1. The relevant statutory provisions are:

(a) ERISA 514(a), (codified at 29 U.S.C. 1144(a) (1988)), which provides that:

> Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III of this Chapter shall supersede any and all State laws insofar as they may now or hereafter related to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect of January 1, 1975.

(b) ERISA 514(b)(2)(A), (codified at 29 U.S.C. 1144(b)(2)(A) (1988)), the insurance saving clause, which provides that:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(c) Title 40 Public Health and Safety, Chapter 12, Health Care Cost Control, (40:2201, et seq.), of the Louisiana Revised Statutes of 1950, a copy of which is set forth in the appendix at 37a to 42a.

STATEMENT OF THE CASE

This action involves a challenge by an HMO and an insurance company, under the Supremacy Clause of the United States Constitution, to the statutory method by which Louisiana, through its health care laws, controls health care costs without jeopardizing the quality of care received by patients. Claiming

jurisdiction under 28 U.S.C. 1331, and the *Ex parte Young* exception to the State's Eleventh Amendment immunity from suit in federal court, plaintiffs-respondents Cigna Health Plan of Louisiana, Inc. ("CIGNA") and Connecticut General Life Insurance Company ("CGLIC") filed a complaint seeking declaratory and injunctive relief on the theory that the Any Willing Provider provision of Louisiana's Preferred Provider Organization enabling statute violated the Supremacy Clause of the United States Constitution, on July 19, 1994, in the Middle District of Louisiana, in Baton Rouge, Louisiana, naming as defendant the State of Louisiana through its Attorney General, Richard P. Ieyoub.[1] Although claiming *Ex parte Young* type of injury, notably, they did not pray for a temporary restraining order.

On August 9, 1994, the State of Louisiana filed a Motion to Dismiss the case, based upon the Eleventh Amendment, the Declaratory Judgment Act, the Federal Injunction Act, Failure to State a Cause of Action, Lack of Standing, and Lack of an Actual Case of Controversy to both counts of the Petition, which was set for hearing by the Court on March 17, 1995, as the earliest available date. Plaintiffs then filed a Motion for Summary Judgment on October 13, 1994, noticing it for hearing on the same day as the State's Motion to Dismiss. The State filed its Opposition on October 20, 1994. Before the hearing, the Middle District Court transferred the case to the Eastern District of Louisiana, in New Orleans. The Eastern District denied Plaintiffs' Fourteenth Amendment complaint, but, ironically, dismissed the State's Eleventh Amendment claims and found ERISA preemption, enjoining Louisiana's Attorney General from enforcing the state statute.

The Court of Appeals below held that the suit was not barred by the Eleventh Amendment because it is "well estab-

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[1]CIGNA and CGLIC also sought declaratory and injunctive relief on the theory that the Any Willing Provider statute violated the Fourteenth Amendment of the United States Constitution. The district court dismissed the claim for failure to state a claim. CIGNA and CGLIC did not challenge this ruling on appeal.

lished that the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law" and that federal law was violated because ERISA preempts the Louisiana statute in that it "relates to "employee benefit plans within the meaning of ERISA's preemption clause. It held further, that the statute is not exempted from preemption by ERISA's" insurance savings clause" because the statute failed to meet the third factor of the ***Metropolitan Life*** test[2]. The Court thought it sufficient for preemption under ERISA that "on its face, Louisiana's statute obviously is not 'limited to entities within the insurance industry,'" because it "specifies, in a non-exclusive list, that it 'applies' to "self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs," as well as 'health care financiers, third party administrators, providers, or other intermediaries.'" La. Rev. Stat. Ann. 40:2202(3)(a) and (b).

However, the statute does not state that "it applies" to self-insured plans. It specifically states that a preferred provider organization shall mean a contractual agreement between a provider and a group purchaser to provide health care services. It confers the right upon self-insured plans to employ such a contract, should *they* so choose. Thus, it does not relate to ERISA plans, because it regulates a contract of insurance and affects plans only in an indirect economic manner.

Similarly, the Appellate Court dismissed Louisiana's and its Attorney General's claims of sovereign immunity as "patently without merit." A3, FN1. The Fifth Circuit relied heavily upon its own decision, to disregard Louisiana's and its Attorney General's Eleventh Amendment immunity in deciding this matter. A3, FN1. That decision pre-dates one of this Court's latest authorities on the subject which holds that a state may not be sued in its own name, regardless of the relief sought and pre-dates this Court's latest expression of the law holding that Congress may not abrogate that immunity even when the Constitution vests in Congress

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[2]*Metropolitan Life Insurance Co. v. Travelers Insurance Co.*, 471 U.S. 725, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

complete law-making authority over a particular area, ie., in pre-emption issues.

The Fifth Circuit reasoned, by relying on its previous case, that whenever a plaintiff *alleges* that state officials are violating federal laws, a federal court *always* has jurisdiction to determine whether or not a violation has occurred. Such a legal hypothesis runs contra to the *Ex parte Young* Court's opinion itself, which warned that such action is not consistent with the Constitution.

The decision further conferred employer standing under ERISA on HMOs and insurance companies, by directly holding that such standing does not matter. 11a.

A. Louisiana's Preferred Provider Organization Enabling Statute

1. *The Overall System*

As part of its effort to assure access to quality health care services, to preserve patient choice, and to control health care costs, (see La. Rev. Stat. 40:2201), Louisiana enacted a Preferred Provider Organization (PPO) statute authorizing the formation of preferred provider organizations, La. R.S. 40:2201(C), within Title 40 of its Revised Statutes, entitled Public Health and Safety. The Louisiana Legislature declared at La. R.S. 40:2201(2), that it enacted the statute to meet federal standards and regulations. Thus, the Attorney General sought in good faith, to enforce the statute. He did not seek to defy federal law, unlike the Attorney General of *Ex parte Young*.

The legislature defined at La. R.S.40:2202, certain terms among which are those pertinent to this matter. It defines a PPO as a contractual agreement between a health care provider and a group purchaser to provide for alternative rates of payment in which the provider agrees to accept the alternative rate and the agreement may also provide incentives to the insured employee to utilize the participating providers. La. R.S. 40:2202(5)(a),(b). Notably, it characterizes an employee who will utilize the participating providers as "insured."

The statute further defines group purchasers as entities which contract with providers (health care)[see La. R.S.

40:2202(6)] for the purpose of establishing a PPO and may include entities which contract for the benefit of their insured, or self-funded organizations or entities which serve as brokers for the formation of such contracts, including third party administrators like CIGNA and CGLIC. La. R.S. 40:2202(3). Thus, the statute does not state specifically that it "applies to" ERISA plans, an important distinction.

The statute provides in its specific authorization for PPOs provision, La. R.S. 40:2203, that any group purchaser may contract with any provider in any contractual agreement to form a PPO. It also provides that group purchaser members participating in PPOs shall be guaranteed access to their standard benefits under the terms of their policy, or self funded organization benefits, regardless of whether they choose a preferred provider or a provider who does not participate in the preferred provider contract. The remainder of the statute is devoted to regulation of hospital tangible benefits and peer review committees for health care providers.

2. The Any Willing Provider Provision

As part of the state's regulation of this contract between health care providers and health care group purchasers, the statute provides that no licensed provider, other than a hospital, who agrees to the terms of the PPO contract shall be denied the right to offer health care services within the limits of his license. La. R.S. 40:2202(5)(c). The Legislature implemented this provision to achieve its stated goal of protecting the quality of care received by patients and enhancing the ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities and to meet federal and state standards and regulations. La. R.S. 40:2201(A)(1), (2). It is this section of the PPO statute which plaintiffs-respondents sought to invalidate.[3]

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[3]Neither this provision nor the entire statute relates to ERISA plans because the statute and its provision are laws of general applicability which neither single out ERISA plans for special treatment nor are predicated upon the existence of plans and as such have only a tenuous, remote or peripheral connection to employee benefit plans, which have never been held to trigger ERISA preemption. *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, 583, n. 1 (1992).

This contractual requirement operates without regard to whether the group purchaser is or is not a group purchaser for an ERISA plan. The requirement established does not depend upon ERISA status. It operates regardless of whether the contract will be purchased by an ERISA plan. Thus, it is neither predicated upon the existence of ERISA plans nor singles them out for special treatment.

In addition, the challenged Louisiana statute does not restrict any choice that an ERISA plan may have as to form of coverage—self-insured, or commercially insured. It also does not restrict a plan from choosing to cover, in whole or in part, particular kinds of benefits, nor does it require or restrict plans from choosing to purchase a PPO contract from CIGNA or CGLIC. It simply gives ERISA plans the *right* to purchase a contract should they so *choose* and ensures that when they do so, the group members shall be guaranteed access to their standard benefits under their policies or plans regardless of whether they choose a preferred provider or not. La. R.S. 40:2203(C).

B. The Doctrine of Ex parte Young

(I) The Fifth Circuit's Rationale

The Fifth Circuit held that the *Ex parte Young* exception operated to overcome Louisiana's Eleventh Amendment immunity. Plaintiffs-respondents in this case named the State of Louisiana as defendant and sued the State through its Attorney General. Only in the body of the complaint did they assert that they sued the Attorney General in his official capacity. According to plaintiffs-respondents themselves, they could have chosen to sue a variety of persons which they listed in their petition, with the same end result. The Fifth Circuit justified the use of the exception on the ground that an Eleventh Amendment argument was "patently without merit" because it is "well established that the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective, declaratory or injunctive relief to prevent a continuing violation of federal law."

The Court cited a footnote to *Shaw v. Delta Air Lines, Inc.*,[4]

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[4]463 U.S. 85, 96 n. 14, 103 S.Ct. 2890, 77 L.Ed. 2d 490 (1983).

and two of its own cases as authority. In so relying, the Fifth Circuit ignored this Court's abundance of relevant precedent and based its decision on precedent contradictory to that of this Court.

In one of the very cases upon which it relied to deny Louisiana sovereign immunity, the Court itself expressed confusion over the operation of sovereign immunity and the *Ex parte Young* exception by stating in its own words in a dissertation covering numerous pages, that given all of these curious inconsistencies, it is no wonder that lawyers and judges are still confused about the Eleventh Amendment and the doctrine of *Ex parte Young*.[5] The Court further opined at page 1252 of that case, that although the Supreme Court *has sometimes implied otherwise* (emphasis added), *Ex parte Young* is a gaping hole in the shield of sovereign immunity created by the Eleventh Amendment and the Supreme Court. [In other words, the doctrine of *Ex parte Young* is not narrow and may be applied expansively, whenever a lower court so decides, contrary to a profusion of Supreme Court guidance.]

In contrast, however, the *Ex parte Young* exception presents the question of the constitutional validity of a statute because the penalties which it inflicts are so great as to prevent recourse to the courts for the adjudication of respondent's rights under it. (ie., irreparable harm)[6]

In the case at bar, the penalty of the statute is not so great as to prevent recourse to the courts, state or federal, naming a different defendant. (The *Ex parte Young* Court held that the exception was necessary "when the penalties for disobedience are by fines so severe as to intimidate the company from resorting to the courts to test the validity of the legislation." No such severe penalties appear in this civil statute. It provides no terms of incarceration nor penalty provisions of any kind).[7] As proof, plaintiffs-respondents did not even pray for a temporary

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[5]*Brennan v. Stewart*, 834 F.2d 1248, 1251-1255 (5th Cir. 1988).

[6]*Beal v. Missouri Pac. R.R. Corp.*, 312 U.S. 45, 51, 61 S.Ct. 418,421, 85 L.Ed. 577 (1940)

[7]*Ex parte Young, infra*, at 209 U.S. 147, 28 S.Ct. 449.

restraining order as authorized pursuant to Rule 65 (b) of the Federal Rules of Civil Procedure, relief which they surely would have prayed for had their cause arisen to the level of a true *Ex Parte Young* exception. Instead, plaintiffs-respondents were content to allow their case to rest in court for nine months before any adjudication at all was addressed.

(ii) Brief Summary of This Court's Ex parte Young Cases

Unlike the facts in the case at bar, the *Ex Parte Young* Court carved its exception[8] to remedy a situation in which Missouri's attorney general *openly defied* a federal *court order* of injunction by acting contrary to that order. The United States District Court placed the attorney general in prison for contempt of court and the case was brought to court on petition for a writ of habeas corpus. In addition, the suit voiced *Fourteenth Amendment* complaints and the state statute, which carried substantial *imprisonment* and pecuniary *penalties*, imposed *criminal sanctions*. The *Ex Parte Young* Court itself warned that an intolerable situation would arise if *persons* were allowed to *freely contest a state statute's validity* by a proceeding in federal court whenever they were about to be charged with its violation.[9] Thus, this Court has held on many occasions, that the doctrine of *Ex Parte Young* is narrow and is not to be applied expansively. [10]

The facts of the case at bar simply do not fit those of *Ex parte Young*. By sharply departing from the facts of *Ex parte Young* and applying its draconian remedy against the State of Louisiana, the Fifth Circuit has allowed the very same intolerable situation, warned of by the original Court to arise in the case at bar.

In stark contrast to the 5th Circuit's decisions, this Court has consistently held that a presumption against preemption exists in the law.[11] *And significantly*, this Court recently held that even when the Constitution vests in Congress complete law-making

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[8]209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908).

[9]*Ex parte Young* at 209 U.S. 156, 28 S.Ct. 453.

[10]*Edelman v. Jordan*, 415 U.S. 651, 665, 94 S.Ct. 1347, 1357, 39 L.Ed.2d 662 (1972); *Pennhurst, cited infra*, at pgs. 465 U.S. 102, 104 S.Ct. 909.

[11]*New York Blue Cross v. Travelers, infra*, at 115 S.Ct. 1676.

authority over a particular area, (ie., the preemption issue), the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States;[12] a general authorization for suit in federal court does not suffice. The Fifth Circuit's rule of law expressed in *Brennan v. Stewart, supra,* (grant jurisdiction on allegations and try the case to determine if state officials broke federal law) cannot withstand scrutiny in light of the legal precedent set by this Court, because that rule allows a federal court to decide on allegations, without the proof present in *Ex parte Young,* and previous to trial, in order to grant jurisdiction, that a state officer violated federal laws by enforcing in good faith, a statute presumed to be constitutional, conduct startlingly unlike that punished in *Ex parte Young, an extraordinary case.* Such a rule cannot be reconciled with the Constitution. *And,* ERISA, like the Indian Gaming Regulatory Act (IGRA) discussed in *Seminole,* provides a comprehensive scheme for regulation which does not include a congressional intent to abrogate the states' Eleventh Amendment rights, nor is such an intent expressed in the Declaratory Judgment Act. Moreover, the Fifth Circuit expressly declined to follow *Seminole. See* A4, FN1.

In addition, this Court recently held that the real party in interest in an official-capacity suit is the governmental entity and not the "named" official.[13] Further, this Court has held on many recent occasions that unless a State has waived its Eleventh Amendment immunity or Congress has overridden it, a State cannot be sued directly in its own name *regardless of the relief sought.*[14]

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[12]*Seminole Tribe of Florida v. Florida,* _ U.S. __, 116 S.Ct. 1114, 1131, 134 L.Ed.2d 252 (1996).

[13]*Hafer v. Melo,* 502 U.S. 21, 25, 112 S.Ct. 358, 361, 116 L.Ed.2d 301 (1991); *Kentucky v. Graham,* 473 U.S. 159, 166, 105 S.Ct. 3099, 3105, 97 L.Ed.2d 114 (1985).

[14]*Alabama v. Pugh,* 438 U.S. 781, 98 S.Ct. 3057, 57 L.Ed.2d 1114 (1978)(per curiam); *Florida Dept. Of State v. Treasure Salvors, Inc.,* 458 U.S. 670, 684, 102 S.Ct. 3304, 3314, 73 L.Ed.2d 1057 (1982); *Cory v. White,* 457 U.S. 85, 91, 102 S.Ct. 2325, 2329, 72 L.Ed.2d 694 (1982); *Pennhurst State School & Hospital v. Halderman,* 465 U.S. 89, 101-102, 104 S.Ct. 900, 908-909, 79 L.Ed.2d 67 (1984); *Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, Inc.,* 506 U.S. 139, 144, 113 S.Ct. 684, 687-688, 121 L.Ed.2d 605(1993); *Welch v. Texas Dept. Of Highways and Public Transportation,* 483 U.S. 468, 480, 107 S.Ct. 2941, 2949-2950, 97 L.Ed.2d 389 (1987).

In addition, as in the case at bar, when a plaintiff names the state itself as a defendant, a suit against state officials that is in fact a suit against the state is barred regardless of whether it seeks damages or an injunction.[15] and when a state legislature adopts legislation, its actions constitute those of the State.[16] Equally important, a state statute may be enjoined only if it is unconstitutional on its face.[17] Thus, both lower courts should have barred this federal suit against the State of Louisiana by private parties.

C. Decisions Below

1. *District Court*

Respondents CIGNA and CGLIC initially commenced a civil action against the State through its Attorney General on July 19, 1994, seeking, *inter alia*, a declaratory judgment invalidating Louisiana's Any Willing Provider provision under ERISA, through the Declaratory Judgment Act, the Supremacy Clause of the United States, and the Fourteenth Amendment and an injunction against enforcement of the statute.

Ironically, while the District Court dismissed respondents' Fourteenth Amendment claim on April 17, 1995, it granted respondents' motion for summary judgment on the ERISA preemption issue, and, failing to note the extraordinary nature of the doctrine of *Ex parte Young*, expansively and routinely enjoined Richard P. Ieyoub, in his official capacity as the Attorney General of Louisiana, from bringing suit against plaintiffs for alleged violations of La. R.S. 40:2202(5)(c), from issuing a Notice of R.S. 51:1401 Complaint letter and from applying advisory opinion No. 92-824, issued February 8, 1993, as if the State of Louisiana were an ordinary litigant.

The Court reaching the merits of the case, after holding in a foot note that the State's defenses under the Eleventh

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[15]*Cory v. White*, at 457 U.S. 91, 102 S.Ct. 2329; *Pennhurst State school & Hospital v. Halderman*, at 465 U.S. 101- 102, 104 S.Ct. 908-909.

[16]*Parker v. Brown*, at 317 U.S. 352, 63 S.Ct. at 314; *Hoover v. Ronwin*, 466 U.S. 558, 567-568, 104 S.Ct. 1989, 1995, 80 L.Ed.2d 590 (1984).

[17]*Rice v. Norman Williams Co.*, 458 U.S. 654, 659, 102 S.Ct. 3294, 3298-3299 (1982).

Amendment were patently without merit, held that the statute impacted the employers' or *plan sponsors'* discretion as to how health benefits may be structured under their employee benefit plans and also held that the statute 'related to' employee benefit plans, employing the decision of the Fourth Circuit Court of Appeals in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, cert. denied, 114 S.Ct. 579 (1993) as its ground. However, ironically, in contrast to the appellate court's decision in *Stuart Circle*, the District Court concluded that ERISA's saving clause did not save Louisiana's statute from preemption. As a direct result of this decision, the main thrust of ERISA, the avoidance of a multiplicity of regulation, has been frustrated.[18]

2. Court of Appeals

On April 30, 1996, the Fifth Circuit issued its decision affirming the District Court's holding that the Eleventh Amendment did not bar this suit and that ERISA preempted Louisiana's Any Willing Provider Statute, again frustrating the main thrust of ERISA. The Court held that even though the State was named as defendant through its Attorney General, and the suit was one against a state official in his official capacity, Louisiana's Eleventh Amendment claim was patently without merit and found that the statute both referred to ERISA plans and had a connection to ERISA plans. The Court reasoned that the statute prohibited those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider and as such connected with ERISA plans. It specifically rejected this Court's recent holding regarding indirect economic influence, in the *Travelers* case,[19] by reasoning that the holding was limited, and refused to follow the reasoning of the Fourth Circle in *Stuart Circle*, cited above, which held the Virginia statute saved from preemption. The Court further held that the statute was not saved from preemption because it did not meet the third factor of the *Metropolitan Life* test, cited above. On June 4, 1996 the Court also denied the state's petition for rehearing.

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[18]*New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995).

[19]*Id.*

REASONS FOR GRANTING THE WRIT OF CERTIORARI

This decision warrants review for several reasons. First, insofar as the Fifth Circuit found that the statute was not saved from preemption under ERISA, it put itself in direct conflict with a decision of the Fourth Circuit, holding a virtually identical provision of Virginia law not preempted by ERISA. *See Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, cert. denied, 114 S.Ct. 579 (1993). In rejecting the challenge to Virginia's "any willing provider" provision, the Fourth Circuit held that ERISA did not preempt the state's "Any Willing Provider" provision because it was saved from preemption by ERISA's saving clause.

Second, this ERISA preemption issue and the issue of the expansion of the doctrine of *Ex parte Young* are of considerable importance to all states. The Fifth Circuit barred Louisiana from exercising the regulatory authority allowed to its sister states, Virginia, and Texas. Furthermore, all states are placed in the quandary of not knowing whether—or in what manner—they can carry out traditional police powers of regulating health care provider services. The result seriously impedes patient choice and a provider's right to earn a living. In addition, by ignoring this Court's precedent, this decision set its own precedent that places all States and their Officers in the dilemma of not knowing whether whenever they might enforce a state statute against a private plaintiff, that private party might at any time file a declaratory and injunctive complaint for a speedy judicial determination of questions of constitutional law in federal court, a mode of relief which is inconsistent with the Eleventh Amendment.

Third, the Fifth Circuit's decision expands both preemption and the abrogation of Eleventh Amendment rights beyond reasonable bounds. The Louisiana law is indisputably a law of general application that makes no distinctions whatsoever with respect to ERISA plans. To the extent that ERISA plans may have an incentive to choose a PPO, they stand in exactly the same footing as everyone else. The Louisiana law does not relate to ERISA plans because it is a health care law which regulates the substantive terms of a contract of insurance, with mandatory-provider

regulations, conceptually similar to the mandatory-benefit health care law declared, by the *Metropolitan Life* Court, a law regulating insurance and consequently not preempted by ERISA. *(See Metropolitan Life Insurance Co. v. Massachusetts Travelers Ins. Co., and Stuart Circle*, cited above). The Louisiana law only "relates to" ERISA plans—in the words of the ERISA preemption provision—only in the sense that *any* general law regulating PPOs "relates to" a plan: that is, by subjecting the plan to burdens and benefits like others similarly situated. That has not been, and should not be grounds for preemption of state law. *See Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988).

Similarly, the Louisiana statute does not impinge upon the objectives of ERISA by mandating employee benefit structures or benefits in the sense required for pre-emption, does not provide alternate enforcement mechanisms, does not operate to "effectively restrict" the choice of policies available in the market, is not predicated upon the existence of ERISA plans, but rather regulates a contract of healthcare insurance.

Further, the *extraordinary* remedy created by the doctrine of *Ex parte Young* should not be applied expansively and routinely by federal courts against the states to determine if the officers of the sovereign states "are violating federal law." (In *Ex parte Young*, Missouri's attorney general was jailed for contempt of court at the beginning of the action). Recent precedent set by this Court holds that, even in preemption issues in areas where Congress has legislated exclusively, it did not intend to abrogate the States' Constitutional right guaranteed by the Eleventh Amendment. If Congress did not intend such a result, the Fifth Circuit upset the Constitutional balance of power by usurping Congress' powers in this matter. By expressly declining to follow this precedent and allowing a suit against Louisiana by private parties in this preemption case, both lower courts rendered the Eleventh Amendment meaningless.

Fourth, the Fifth Circuit's decision directly conflicts with prior precedent and relevant decisions of this Court. It conflicts with the cases referenced in the third reason, as well with the *New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co, supra*, and *Seminole Tribe of Florida v. Florida, supra*, (even when the

Constitution vests in Congress complete law-making authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting states) and other relevant Eleventh Amendment cases (discussed, supra, in the summary of the *Ex parte Young* cases) which have set forth the principles that a suit against a state in its own name is barred regardless of the relief sought, that suits against a state officer in his official capacity are suits against the state, the exception of *Ex parte Young* is not be applied expansively and Congress must express intent to abrogate states' Eleventh Amendment rights in the body of the statute. (*Blatchford v. Native Village of Noatak*;[20] *Atascadero State Hospital v. Scanlon*).[21] Congress has not expressed an intent to abrogate those rights in either ERISA or the Declaratory Judgment Act, under which this suit was brought. A general authorization for suit in federal court does not suffice.

I. A DIRECT CONFLICT EXISTS BETWEEN TWO CIRCUIT COURTS ON AN ISSUE OF CONSIDERABLE IMPORTANCE

A. Conflict Between Two Circuits

The decision of the Fifth Circuit in this action is in direct conflict with the Fourth Circuit's decision in *Stuart Circle, supra*. While the Fifth Circuit held that ERISA *preempts* Louisiana's "any willing provider" statute, the Fourth Circuit held that ERISA *did not* preempt Virginia's similar law. The Fifth Circuit's decision reflects the narrow reading of the saving clause rejected by this Court in *Metropolitan Life*, by distinguishing between insurance laws and health care laws.[22] For all intents and purposes, the any willing provider provision under Louisiana law is indistinguishable from the Virginia law, given that they both mandate that no provider willing to meet the terms and conditions of the contract

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[20]501 U.S. 775, 779, 111 S.Ct. 2578, 2581, 115 L.Ed.2d 686 (1991).

[21]473 U.S. 234, 238-239, 105 S.Ct. 3142, 3145, 3146, 87 L.Ed.2d 171 (1985).

[22]*Metropolitan Life*, 471 U.S. at 746, 105 S.Ct. at 2393 (Nothing in the language, structure, or legislative history of the Act supports this narrow reading of the clause).

shall be excluded. Further, both statutes regulate the relationship between insurer and insured. In addition, in both statutes, an insurer has considerable latitude in determining the manner in which it selects a preferred provider for its preferred provider organization. Neither section defines "terms and conditions" but rather implies that such terms are variable and dependent upon the specific context in which a PPO is established. The results in the two cases are thus irreconcilable.

Essentially, the two Courts reached these conflicting results due to diametrically opposed analyses of the significance under ERISA of an economic and administrative impact upon ERISA plans and analysis under the "common sense" definition of insurance, utilizing the *Metropolitan Life factors*. (However, while the Virginia statute does not mention ERISA plans in any way, the Louisiana statute provides that ERISA plans may utilize PPOs). The Fifth Circuit noted the Fourth Circuit's decision, and followed it insofar as it found that the Louisiana statute "related" to ERISA, but declined to follow its analysis regarding the *Metropolitan Life* factors.

The Fifth Circuit held that Louisiana's statute related to ERISA plans and was not saved from preemption by ERISA's saving clause because it failed to meet the third prong of the *Massachusetts Life* test by specifying that it "applies" to self-funded and other organizations. 15a. In contrast, the test for preemption ... is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied.[23] In *Greater Washington Bd. of Trade*, the Court preempted statutes which could not be meaningfully applied without reference to ERISA plans. Here, the Louisiana statute would function in exactly the same way even if ERISA plans did not provide health care coverage as a benefit or even if they did not choose to utilize PPOs.

According to the Fifth Circuit, regardless of whether the self-funded plan has a choice of whether to utilize an insurer's PPO, the statute is unconstitutional on its face because "it applies" to self-insured plans and in turn, specifically mandates

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[23]*Greater Washington Bd. Of Trade*, supra, at 113 S.Ct. 583-584; *NYS HMO Conference v. Curiale*, 64 F.3d 794, 800 (2nd Cir. 1995).

that certain benefits available to ERISA plans must be constructed in a particular manner,[24] which in turn does not merely raise the cost of the implicated benefits; it also delineates their very structure. Similarly, the Court found that the fact that neither CIGNA nor CGLIC (plaintiffs-respondents) is itself an ERISA plan was inconsequential to the issue of standing and found HMOs and insurers to be within the same class of ERISA protection as employers. 8a, FN18, 11a.

On the other hand, while the Fourth Circuit acknowledged this Court's rationale in *Metropolitan Life* that mandatory-provider regulations were conceptually similar to the mandatory-benefit law, [found not related to ERISA], it nevertheless found it necessary to hold the law *saved* from preemption on the basis of *Metropolitan's* test. In its case, the Fourth Circuit rejected the District Court's reasoning that the Virginia statute affected ERISA plans by regulating the structure of an insurer's PPO, (the reasoning affirmed by the Fifth Circuit). The Fourth Circuit reasoned that the statute applied to plans because it had a provision relating to benefits which an insured may receive from an insurer's PPO and restricted the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit health plan to those preferred by the insurer, regardless of whether the participant could select a provider outside the plan, albeit at the expense of forfeiting some of his benefits; however, notwithstanding, the Court held that the law was *saved* from preemption by the saving clause.

It is difficult to see how the Fifth Circuit found, when there exists a strong presumption against preemption, that it was Congress' "clear and manifest intent" to preempt the Louisiana law, given that it was enacted at least ten years after ERISA and was designed to regulate the recent use by managed care of programs of restricted health care provider networks. Obviously, Congress could not in 1974 when it passed ERISA have had a "clear and manifest" intent to prohibit state regulation of a health

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[24](ERISA does not regulate the substantive content of welfare-benefit plans). *Metropolitan Life*, 471 U.S. at 732, 105 S.Ct. at 2380; *Shaw v. Delta Airlines*, at 463 U.S. 91, 103 S.Ct. 2896-2897.

industry business practice that had not yet emerged and that was only indirectly related to ERISA plans. On the contrary, Congress warned that entrepreneurs with a profit motive would try to assert that their plans were ERISA plans, but that they were no more ERISA plans that any other type of insurance.[25] *And*, Congress did not intend to preempt areas of traditional state regulation. In the same vein, it is difficult to see how the Court found that the Louisiana law related to ERISA plans given that the *Metropolitan Life* Court previously held that health care laws regulating contracts of insurance were insurance laws not requiring salvation from preemption.

Beyond this, the Fifth Circuit found, that a statute must both fit the common sense definition of insurance regulation and the Court must answer "yes" to each of the questions in the three part *Metropolitan Life* test to escape ERISA preemption, relying on its own decision. 14a,[26] which encompassed litigation between the primary ERISA parties. In contrast, this Court moved away from rigid application of the McCarran-Ferguson Act criteria in *United States Department of the Treasury v. Fabe*, 113 S.Ct. 2202 (1993) and the so-called common sense definition of insurance regulation is essentially equivalent to one of the prongs of the three-part *Metropolitan Life* test.[27] Furthermore, none of the three criteria is, by itself, determinative.[28]

Moreover, this Court has never expressly required the application of the McCarran-Ferguson "business of insurance" test to ERISA saving clause issues. Indeed, its opinion in *Metropolitan Life* merely noted that the business of insurance analysis *also sup-*

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[25]*MD Physicians & Associates, Inc.*, cited *infra*, at page 184.

[26]*Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993).

[27]Compare the common-sense definition as set forth in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987) [to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry] with the third factor of the *Metropolitan Life* test at 105 S.Ct. 2391, (whether the practice is limited to entities within the insurance industry).

[28]*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

ported its conclusion that the statute at issue regulated insurance.[29]

In particular, this Court has previously and unequivocally held that a health care law which regulates a contract of insurance is not pre-empted by ERISA,[30] and that it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws, those laws being only one variety of a matrix of state laws that regulate the substantive content of health-insurance policies to further state health policy.[31]

B. Issues of Considerable Importance

The issue that divides the Fourth and Fifth Circuits is of great significance to a state's ability to exercise a fundamental state police power—the regulation of health care, balancing the control of its costs without jeopardizing quality of care received by patients and the ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities. *See e.g., Hillsborough Count v. Automated Medical Lab, Inc.*, 471 U.S. 707, 719 (1985) ("the regulation of health and safety matters is primarily, and historically, a matter of local concern").

Pursuant to its traditional police powers as well as a constitutional mandate to promote the health, safety, education, and welfare of the people of Louisiana, the State has enacted laws designed to foster a fair and efficient system to control health care costs. *See, e.g.*, La. Const. Of 1974, Preamble; La. R.S. 40:2201. This action now threatens Louisiana's ability to achieve these balanced objectives.

Aside from incapacitating Louisiana's effort to keep the system fair for patients and health care providers alike, the Fifth Circuit's decision will incapacitate such efforts of every other state with similar laws. Should a state continue to regulate PPOs in any form, that state not only faces certain litigation, it also

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[29] *Metropolitan Life*, 471 U.S. at 742-744.

[30] *Id.* at pgs. 471 U.S. 741-743, 105 S.Ct. 2389-2391.

[31] *Id.* at pages 729, 2384.

faces potentially crippling liability coupled with a decline in the quality of patient care as well as a decline in the number of health care providers willing to remain in Louisiana as a result of the Fifth Circuit's erroneous decision.

Further, within the State of Texas, a recent court decision upheld[32] an ERISA challenge to its any willing provider provision, which may be overturned by the Fifth Circuit on appeal. Similar litigation is occurring in the State of Massachusetts.[33]

In addition to precluding a state's ability to achieve its own traditional police power objectives, the Fifth Circuit's decision will impede federal constitutional principles of equal protection of the law in that it grants to HMOs and big insurance companies a favored position over the rights of Louisiana citizen-patients and health care providers. Furthermore, the decision runs contrary to the legislative intent of ERISA by placing HMOs and insurers in the same class as employers who establish ERISA covered plans.[34]

Finally, the Fifth Circuit decision gives rise to the broader issue regarding the extent to which states can enact any law regulating the operation of health care providers. The Third Circuit in *United Wire, Metal & Machine Health & Welfare Fund v.*

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[32]*Texas Pharmacy Assoc. v. Prudential Ins. Co. Of America*, 907 F.Supp. 1019 (W.D. TX 1995). (Texas "any qualified provider" statute fell within the insurance savings clause of ERISA and therefore was not preempted).

[33]*American Drug Stores Inc., d/b/a Osco Drug Stores v. Harvard Pilgrim Health Care, Inc. and Prudential Insurance Co. Of America*, (Civil Action No. 96-10084-MEL, MA. District, 1996).

[34]*MD Physicians & Associates, Inc. v. State Board of Insurance*, 957 F.2d 178, 184 (5th Cir. 1992) (entrepreneurs whose primary interest is in profiting from the provision of administrative services through the formation of insurance companies and related enterprises will argue that its enterprise is an ERISA benefit plan which is protected by ERISA's preemption provision. These programs are not 'employee benefit plans; these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction. Activity Report of the Committee on Education and Labor). (We do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the employee benefit plan. H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

Morristown Memorial Hosp., 995 F.2d 1179 (3d Cir.), *cert denied*, 114 S.Ct. 383 *reh'g denied*, 114 S.Ct. 651 (1993), suggested that if state laws were invalidated due to indirect economic impact, then a host of other state health laws may be preempted because they have some indirect impact on costs. Under the same rationale, any law which has the potential of increasing the insurer's cost of doing business, and accordingly, its billings to plan participants, would be preempted, such as laws providing minimum standards for physician and nurses certification, medical malpractice suits against hospitals and physicians, hospital minimum staffing levels for physicians and nurses, record-keeping requirements, construction codes and infection control procedures could also be preempted. *See, e.g.*, La Revised Statutes, Public Health and Safety, Title 40, and La Revised Statutes, Professions and Occupations, Title 37. Without clear guidance from this Court, this action will likely spawn challenges to these and other fundamental state health laws, seeking to immunize ERISA plans from any costs associated with those laws.

Of equal importance to states is the impact of the Fifth Circuit's denial of Eleventh Amendment immunity to a state and its chief legal officer. The result of this decision, is, in the Fifth Circuits own words, a "gaping hole" in states' Eleventh Amendment immunity, which runs counter to the significant body of case law developed since the *Ex parte Young* decision was rendered. The Fifth Circuit set a dangerous precedent, in sharply departing from the facts of *Ex parte Young* to apply its exception and fell into the very trap[35] against which the *Ex parte Young*

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[35] "If, because they were law officers of the state, a case could be made for the purpose of testing the constitutionality of the statute, by an injunction suit brought against them, then the constitutionality of every act passed by the legislature could be tested by a suit against the governor and the attorney general, based upon the theory that the former, as the executive of the state, was, in a general sense, charged with the execution of all its laws, and the latter, as attorney general, might represent the state in litigation involving the enforcement of its statutes. That would be a very convenient way for obtaining a speedy judicial determination of questions of constitutional law which may be raised by individuals, but it is a mode which cannot be applied to the states of the Union consistently with the fundamental principle that they cannot, without their assent, be brought into any court at the suit of private persons." *Ex parte Young* at 28 S.Ct. 453.

Court warned. Without clear guidance from this Court, this action will likely engender constitutional challenges to a host of other state laws through the states' attorneys general.

Importantly, the Fifth Circuit's rule of law expressed in *Brennan, supra*, cannot survive scrutiny (grant jurisdiction on allegations and try the case to determine if state officials broke federal law). Under this rationale, a federal court may make a decision, on allegations alone and prior to trial, that a state official has broken a federal law, and grant jurisdiction based vaguely, on *Ex parte Young*. Such action is inconsistent with the Constitution of the United States.

II. THE FIFTH CIRCUIT WRONGLY EXPANDED THE SCOPE OF ERISA PREEMPTION

This case represents the first time a Circuit Court decision can be read to hold that a law of general application, mandates employee benefit structures simply because it has an indirect economic impact on ERISA plans, when and if, the plans choose to utilize the benefits of the statute by purchasing a specific contract for health services, a PPO contract. If this Court sustains this interpretation, ERISA plans will lead a "charmed existence that was never contemplated by Congress." *United Wire*, 995 F.2d at 1194, *quoting Rebaldo*, at 138-39. Moreover, it represents the first time a Circuit Court decision can be read to hold that a health care law is not an insurance law and therefore, relates to ERISA plans. (This Court previously held that a health care law cannot be distinguished from an insurance law in *Metropolitan Life*).

While Louisiana Revised Statutes Public Health and Safety Law section 2202(3), defines ERISA plans as among those purchasers who may purchase a PPO contract, it neither specifically applies to ERISA plans, unless the plans choose to purchase such contract, nor is it predicated upon the existence of ERISA plans. To the contrary, it applies to a contract between health care purchasers and providers to provide health care services (an insurance contract), irrespective of ERISA plans. In its definitional section, La. R.S. 40:2202(3)(a), for example, it merely provides a definition of group purchaser which, as an example, may include self-funded insurers, giving them a choice. It does not require

that self-funded insurers purchase such a contract. It also names a variety of other organizations who may purchase the contract. It does not single out ERISA plans for special treatment. Section 2202(3)(b) defines group purchasers as entities which serve as *brokers for the formation of such contracts* as intermediaries, including examples.

Significantly, these provisions speak to group purchasers of a contract between them and health care providers, and not to ERISA benefits for ERISA plan participants and beneficiaries. The provisions do not restrict an ERISA plan from determining its form or level of benefits. ERISA plans are free to self-insure, join an HMO, or insure through commercial insurance. And, regardless of the funding method, an ERISA plan is free to set the terms and conditions of the contract. *See*, La. R.S. 40:22025(c).

The Fifth Circuit failed to consider the ruling in *Metropolitan Life*, at 105 S.Ct. 2389-2391, which made it clear that health care laws are insurance laws, that *do not relate* to benefit plans in the first place, and therefore do not need to be saved from preemption.

At most, the Louisiana law has an indirect economic impact, that affects ERISA plans in the same manner as it affects other consumers and providers of health insurance. This indirect impact is simply insufficient to justify preemption. Otherwise, ERISA plans would be exempt from any state regulation that indirectly affects the cost of doing business, including rent control laws, labor laws and highway tolls.

As recognized by the Third Circuit in *United Wire*, this court already has rejected such an expansive approach to ERISA preemption. In *Mackey*, this Court ruled that ERISA did not preempt the application of a state garnishment statute to ERISA plans even though it created substantial costs to such plans. This finding is wholly in accord with this Court's long-standing principle that ERISA does not preempt state laws that have "only a 'tenuous, remote, or peripheral' connection with covered plans ... as is the case with many laws of general application."[36]

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[36]*Greater Wash. Bd. of Trade, supra*, at 113 S.Ct. 583 n.1, *quoting Shaw v. Delta Air Lines, supra.*

Equally important, the Fifth Circuit failed to consider whether Congress intended for ERISA to preempt generally-applicable state health care laws, in particular. This failure is contrary to a line of Supreme Court cases, the latest of which is *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, at 115 S.Ct. 1666-1667, that establish Congressional intent as the "ultimate touchstone" in any pre-emption analysis. *E.g. Cipollone v. Liggett Group*, 112 S.Ct. 2608, 2617 (1992), *quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978). This line of cases applies the preemption doctrine cautiously to prevent federal laws from intruding onto traditional state police powers, absent compelling evidence of Congressional intent. *E.g., Rice v. Santa Fe Elevator Corp., supra*, at 331 U.S. 230. (preemption analysis "starts with the assumption that the historic police powers of the States [are] not to be superseded ... unless that [is] the clear and manifest purpose of Congress"); *Alessi v. Raybestos-Manhattan, Inc*, 451 U.S. 504, 522 (1981) (the need for unmistakable Congressional intent is "guided by respect for separate spheres of governmental authority preserved in our federalist system").

Given these cases and the Congressional intent reported by the 5th Circuit in *MdPhysicians, supra*, this decision cannot stand because it operates in contradiction to Congressional intent. In determining whether Congress intended to preempt state regulation of health care costs and charges, it is necessary to examine what Congress has said, and legislated, on both employee benefits and health care. *United Wire and Metropolitan Life* undertook such a dual analysis; the decision below did not. Moreover, the Fifth Circuit undertook such an analysis of Congressional intent itself in *Mdphysicians, supra*, which contradicts its decision in this matter. While paying heed to Congress' intent to broadly pre-empt state laws under ERISA, the Fifth Circuit simply ignored twenty-five years of Congressional legislation and encouragement of state efforts to regulate health care.

Although these tests have never been mandatory, even if this Court finds that the statute "relates to" ERISA plans unlike the *Metropolitan Life* Court, then, the question would become whether the statute is within the insurance saving clause, and if

its test were to be applied, the correct analysis should have been: (1) the statute meets the common sense definition of insurance regulation because it is clearly designed to regulate insurance contracts, by providing that a PPO shall mean a *contractual* agreement between a provider and a group purchaser', thus it regulates a *contract of insurance*, not ERISA plans; (2)(a) the statute has the effect of spreading the policyholders' cost risk, because it spreads the "cost component of the policyholders' risk among all insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking health care services from an excluded physician of his or her choice; (2)(b) the statute is an integral part of the policy relationship between the insurer and the insured because it ensures that all policyholders have the option of visiting a qualified health care provider of his or her choice without paying an increased cost for that option; thus, it does not distinguish and set apart ERISA plans for special treatment, but, instead is even-handed in its application toward consumers, like the statute in the *Travelers* case, supra; It only has the potential effect of increasing the cost of business for HMOs and insurance companies, that sell PPOs, founded by entrepreneurs, whose main intent is profit; (2)(c) it satisfies the third factor, by limiting its effect to entities within the insurance industry because, the any qualified provider statute imposes requirements only on the insurers, with the intent of affecting the relationship between the insured and the insurer, through a contract of insurance to provide health care services.

III. THE FIFTH CIRCUIT WRONGLY EXPANDED THE SCOPE OF EX PARTE YOUNG

The Fifth Circuit's finding that the exception of *Ex parte Young* abrogates Louisiana's and its Attorney General's sovereign immunities suffers from the same faulty reasoning employed in its ERISA analysis, ie., an unwarranted expansion of legal principles, and an encroachment into the police powers of the state. Despite this case's dissimilarity from traditional *Ex parte Young* and Eleventh Amendment analysis, the Fifth Circuit has taken a novel approach to a state's Eleventh Amendment immunity and the *Ex parte Young* exception, one not supported by the case law.

In its analysis, the Fifth Circuit's decision conflicts with and ignores, the large body of case law developed by this Court regarding the exception, including its most recent decision in *Seminole Tribe of Florida, v. Florida, supra,* which the Fifth Circuit expressly found did not apply to the circumstances of this matter. 4a, FN1. The uncertainty created by the Fifth Circuit's ruling on sovereign immunity is appropriate for resolution by this Court. For the following reasons, this ruling is also erroneous.

The Fifth Circuit's decision reflects its own principle of law, 3a, FN1, (*see Brennan v. Stewart, supra and infra*) that a federal court may determine in *advance of trial* that a state officer has violated federal law sufficient to confer jurisdiction based upon the doctrine of *Ex parte Young,* without legal analysis of the doctrine. Given this Court's strong legal presumption against preemption, this legal philosophy is inconsistent with the Constitution.

More specifically, this Court has recently expanded this line of thinking by holding in *Seminole,* its most recent expression of the law, that "we have often made it clear that the *relief* sought by a plaintiff suing a State is *irrelevant* to the question whether the suit is barred by the Eleventh Amendment,[37] and that even when the Constitution vests in Congress complete law-making authority over a particular area, (preemption), the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States;[38] ie., even in preemption cases, the Eleventh Amendment bars suits against the state. These mandates should have guided the Fifth Circuit. It should have barred private entrepreneurs from hauling this unconsenting state into court against its will under the guise of the *extraordinary* doctrine of *Ex parte Young* and through the vehicle of the Declaratory Judgment Act in light of this court's instruction in *Seminole Tribe* at 116 S.Ct. 1123, quoting *Atascadero State Hospital v. Scanlon, supra,* (A general authorization for suit in federal court is not the kind of unequivocal statutory language sufficient to abrogate the Eleventh Amendment).

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[37] *Seminole Tribe* at 116 S.Ct. 1124.

[38] *Id.* at 116 S.Ct. 1131.

Instead, the Fifth Circuit distinguished *Seminole* and dismissed Louisiana's Eleventh Amendment immunity, without any meaningful analysis, disregarding the facts that plaintiffs' 14th Amendment claims were dismissed and not appealed, that the action was not based upon a criminal statute with intimidating provisions and penalties, that Louisiana's Attorney General acted in good faith in attempting to enforce the statute which is an act of the state's legislature, the Attorney General did not defy a federal court order, the suit was not a habeas corpus action, and, neither the Declaratory Judgment Act nor ERISA, abrogate the states' constitutional immunities.

The Fifth Circuit itself, expressed confusion regarding the exception of *Ex parte Young*, in *Brennan v. Stewart*,[39] its own authority and one upon which it relied in making its ruling. It opined that, "(a) federal court always has jurisdiction of a suit seeking to enjoin state officials from violating federal laws. If the officials are not violating federal law, judgment should be entered for the defendants on the merits;"(Emphasis supplied); (ie., the doctrine of *Ex parte Young* is *not* narrow and *may be expansively applied*, in direct contradiction of this court's guidance, and falling into the very constitutionally inconsistent analysis warned against by the *Ex parte Young* Court itself). This argument does not survive scrutiny in this matter, given the force of this Court's profusion of guidance to the contrary and its long-standing and strong legal presumption against preemption.

Also, in *Stewart*, the Fifth Circuit read *Pennhurst* to mean that official-capacity actions for prospective relief are not treated as actions against the State, in direct contrast to the case itself, *Cory v. White, supra, Parker v. Brown, supra, and Hoover v. Ronwin, supra.* Furthermore, it expressly stated that "(a)lthough the Supreme Court has *sometimes implied* otherwise, [FN5] *Ex parte Young* is a gaping hole in the shield of sovereign immunity created by the Eleventh Amendment and the Supreme Court." (emphasis supplied). While stating on page 1253-1254, that "(t)he Eleventh Amendment and the doctrine of *Ex parte Young* together create a relatively simple rule of state immunity", it at

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[39] *supra*, at 834 F.2d 1251-1255.

the same time stated, on page 1253, that "the doctrine continues to confound lawyers and judges alike" and that "(a)t least part of the problem is that the Supreme Court shifts between formalistic recitations of Eleventh Amendment dogma without acknowledging *Ex parte Young* even in a footnote and ruling on the merits of dozens of cases under *Ex parte Young* fiction without mentioning the Eleventh Amendment issue even in passing." As examples, the Court cited *Atascadero State Hospital v. Scanlon, supra,* and *Alabama v. Pugh, supra.*

The Fifth Circuit also failed to note that in *Atascadero,* this Court held that Congress' intent to abrogate the States' immunity from suit must be obvious from "a clear legislative statement," (which is not present in either the Declaratory Judgment Act or ERISA).

Later in the case, the Court opined that "given all these curious inconsistencies, it is no wonder that lawyers and judges are still confused about the Eleventh Amendment and the doctrine of *Ex parte Young.* Thus, the Fifth Circuit erroneously relied upon its own case to decide this matter.

Equally important, given the Court's recent ruling in the *Travelers* case, *supra,* that an indirect economic effect on plans is insufficient to support ERISA preemption, and that the issue of preemption turned on Congressional intent, this Court should have proceeded more cautiously than it did, in finding in advance of trial, that Louisiana's Attorney General violated federal laws, on par with the attorney general in *Ex parte Young,* sufficient to abrogate the State's Eleventh Amendment immunity.

Contrary to the Fifth Circuit's ruling, the exception of *Ex parte Young* does not abrogate Louisiana's and its Attorney General's sovereign immunities in this matter when this Court has previously ruled that suits against an officer of the state in his official capacity are suits against the state itself and not against the "named" official,[40] that unless a State has waived its Eleventh Amendment immunity or Congress has overridden it, a State cannot be sued directly in its own name, regardless of the relief

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[40]*Hafer v. Melo, supra; Kentucky v. Graham, supra.*

sought,[41] that even when the Constitution vests in Congress complete law-making authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States,[42] that the doctrine of *Ex parte Young* is narrow and not to be applied expansively,[43] that when a state legislature adopts legislation, its actions constitute those of the State,[44] and that a state statute may be enjoined only if unconstitutional on its face.[45]

Notably, *Ex parte Young* involved Fourteenth Amendment issues, (which issues in this matter were dismissed by the District Court and never appealed), and a criminal state statute which carried substantial imprisonment and pecuniary penalties, *and*, was a habeas corpus proceeding to extricate the attorney general from jail where he found himself after violating a federal court order, unlike Louisiana's Attorney General. The present matter fits none of these facts and thus, does not fit within the narrow exception, which is not to be applied expansively.

Similarly, this Court has often held that Congress could in the exercise of its enforcement power under *section 5 of the Fourteenth Amendment*, set aside the States' immunity from retroactive damages.[46] Later, this Court accepted certiorari to resolve numerous conflicts in whether even the Civil Rights Act, 42 U.S.C. 1988, could be enforced against a state. This Court unequivocally held that despite its proximity to the Fourteenth Amendment, such actions could not be enforced against either

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[41] *Alabama v. Pugh, supra, n.9; Florida Dept. Of State v. Treasure Salvors, Inc., supra, n.9; Cory v. White, supra, n.9; Pennhurst State School & Hosp. v. Halderman, supra, n.9; Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, supra, n.9; Welch v. Texas Dept. Of Highways and Public Transportation, supra.*

[42] *Seminole Tribe, supra.*

[43] *Edelman v. Jordan, supra, n. 11; Pennhurst, supra, n. 11.*

[44] *Parker v. Brown, supra, n. 12; Hoover v. Ronwin, supra, n. 12.*

[45] *Rice v. Norman Williams Co., supra, n. 13.*

[46] *See, Missouri v. Jenkins* 491 U.S. 274, 279, 109 S.Ct. 2463, 2467, 105 L.Ed.2d 229, quoting *Hutto v. Finney*, 437 U.S. 678, 98 S.Ct. 2565, 57 L.Ed.2d 522 (1978) which in turn cited *Fitzpatrick v. Bitzey*, 427 U.S. 445, 96 S.Ct. 2666, 49 L.Ed.2d 614 (1976).

states or state officials, because the word state was not included in the statute, thus, stemming the tide of suits against states and their officials. The *Michigan State Police* Court asserted that this approach is particularly applicable where it is claimed that Congress has subjected the State to liability to which they had not been subject before. This rule has been upheld in all of the Eleventh Amendment cases cited by Louisiana in this matter. Thus, because Louisiana's health care law was not in existence at the time ERISA was enacted, *and* this Court has previously held that health care laws are not insurance laws, the Fifth Circuit should have dismissed this declaratory judgment action against Louisiana and its Attorney General, based upon the lone fact that Congress did not intend to abrogate the states' Eleventh Amendment immunity either in the Declaratory Judgment Act, or in ERISA, not having made this intention unmistakably clear in the language of the Acts.

And, *equally important*, given the force of this Court's long-standing strong legal presumption against preemption, the Fifth Circuit should have prohibited this suit naming the state as defendant and claiming to sue its Attorney General in his official capacity for performing in good faith, the duty conferred upon him by the people of the State of Louisiana in its Constitution, and statutorily, by the State Legislature as well, to enforce all civil laws enacted by it. Thus, the actions of Louisiana's Attorney General, are inextricably bound to those of the State of Louisiana, and this case is in fact, in name and in law, a suit against the sovereign state of Louisiana, which is inconsistent with the Constitution.

CONCLUSION

This case presents a compelling opportunity for this Honorable Court to resolve a conflict among the circuits and, at the same time, to settle two important Federal questions seriously threatening harmonious Federal-State relationships nationwide regarding the doctrine of *Ex parte Young* and yet another ERISA preemption issue which threatens patient choice and the states' rights to regulate health care. The State of Louisiana, through its Attorney General, respectfully requests this Court to grant its petition for a writ of certiorari for the foregoing reasons.

Respectfully submitted,

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*** Counsel of Record**

APPENDIX A

[Filed June 4, 1996]

In the United States Court of Appeals
for the Fifth Circuit

No. 95-30481

CIGNA HEALTHPLAN OF LOUISIANA, INCORPORATED;
CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Plaintiff - Appellees

v.

STATE OF LOUISIANA, ex. rel. Richard P. Ieyoub,
Attorney General
Defendant - Appellant

Appeal from the Untied States District Court for the
Middle District of Louisiana, Baton Rouge

ON PETITION FOR REHEARING

Before REYNALDO G. GARZA, WIENER, and STEWART, Circuit Judges. PER CURIAM:

It is ordered that the petition for rehearing filed in the above case is denied.

ENTERED FOR THE COURT:

s/
United States Circuit Judge

APPENDIX B

[Filed April 30, 1996]

In the United States Court of Appeals
for the Fifth Circuit

No. 95-30481

CIGNA HEALTHPLAN OF LOUISIANA, INC.;
CONNECTICUT GENERAL LIFE INSURANCE CO.,
Plaintiffs - Appellees,

versus

STATE OF LOUISIANA, Ex Rel. Richard P. Ieyoub,
Attorney General,
Defendant - Appellant.

Appeal from the United States District Court
For the Middle District of Louisiana

Before REYNALDO G. GARZA, WIENER, and STEWART, Circuit Judges. WEINER, Circuit Judge:

Plaintiffs-Appellees CIGNA Healthplan of Louisiana (CIGNA) and Connecticut General Life Insurance Company (CGLIC) filed suit against Defendant-Appellant the State of Louisiana, ex rel. Richard P. Ieyoub, Attorney General[1] (Ieyoub),

[1]In their complaint, CIGNA and CGLIC name Ieyoub, acting in his official capacity, as the defendant in this action. Nevertheless, Ieyoub contends that the Eleventh Amendment bars the suit. The district court rejected this argument out of hand, characterizing it as "patently without merit." We agree with the court's assessment of this issue, as it is well established that the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law. *See. e.g., Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85, 96 n.14, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983); *Saltz v. Tenn. Dep't of Employment Sec.*, 976 F.2d 966 (5th Cir. 1992); *Brennan v. Stewart*, 834 F.2d 1248 (5th Cir. 1988).

seeking *inter alia* (1) a declaratory judgment holding that Louisiana's Any Willing Provider statute[2] is preempted by the Employee Retirement Income Security Act (ERISA)[3]; and (2) an injunction prohibiting the commencement of any action against them for alleged violations of the Any Willing Provider statute.[4] The district court granted summary judgment declaring that ERISA preempts the Any Willing Provider statute insofar as it applies to third party administrators and health care plans that provide services to ERISA-qualified benefit plans, and issued an injunction barring enforcement of the statute against CIGNA and CGLIC. Concluding that the Any Willing Provider statute relates

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Our conclusion is unaffected by the Supreme Court's recent decision in *Seminole Tribe of Florida v. Florida*, 1996 W.L. 134309 (U.S. May 27, 1996) (5-4 decision). There, a sharply divided court held that suits against state officials for prospective injunctive relief are barred "where Congress has prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right." *Id.* at *16. Here, CIGNA and CGLIC do not seek to enforce against Louisiana any cause of action created by Congress; and no congressionally mandated remedial scheme is implicated. Instead, CIGNA and CGLIC seek only to prevent a Louisiana official from violating the Supremacy Clause of the United States Constitution by encroaching on legal terrain that Congress has properly deemed preempted. Accordingly, the Court's holding in *Seminole* does not apply to the circumstances of this case; and we affirm the district court's determination that the Eleventh Amendment does not proscribe this suit.

The district court also rejected Ieyoub's contention that this action is barred by the Anti-Injunction Act. As the Anti-Injunction Act prohibits a federal court from staying a pending state court proceeding, and as CIGNA and CGLIC seek no such stay, we affirm the district court's holding on this issue. *See, e.g., B & A Pipeline Co. v. Dorey*, 904 F.2d 996, 1001 n.15 (5th. Cir. 1990) (citing *Dombrowski v. Pfister*, 380 U.S. 479, 85 S. Ct. 1116, 14 L. Ed. 2d 22 (1965)).

[2]*See* LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992) ("No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his license.").

[3]*See* 29 U.S.C.S. §§ 1001 et seq. (Law. Co-op 1990 & Supp. 1995) .

[4]CIGNA and CGLIC also sought declaratory and injunctive relief on the theory that the Any Willing Provider statute violates the Due Process clause of the United States Constitution. The district court dismissed the due process claim for failure to state a claim. CIGNA and CGLIC do not challenge this ruling on appeal.

to employee benefit plans within the meaning of ERISA's preemption clause,[5] and that the statute is not exempted from preemption by ERISA's insurance savings clause,[6] we affirm.

I. FACTS AND PROCEEDINGS

A. FACTS

1. The Any Willing Provider Statute

In 1984, in an attempt to reduce health care costs without jeopardizing the quality of care received by patients,[7] the Louisiana legislature enacted the Health Care Cost Control Act (the Act).[8] The Act specifically authorizes the formation of preferred provider organizations (PPOs), which are defined as "contractual...agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment..."[9] The definitional section of the Act contains a definition of "group purchaser," then follows the definition with an illustrative list of some of the types of entities that may be included in that category.[10] According to the Act, "group purchasers" may include "[e]ntities which contract for the benefit of their

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[5]*See* 29 U.S.C.S. § 1144(a) (Law. Co-op 1990).

[6]*See* 29 U.S.C.S. § 1144(b)(2)(A) (Law. Co-op 1990) (providing that, with limitations irrelevant, the instant appeal, "nothing in this title shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities").

[7]*See* LA. REV. STAT. ANN. § 40:2201(A) (West 1992).

[8]*See* LA. REV. STAT. ANN. §§ 40: 2201 et seq. (West 1992 & Supp. 1996).

[9]LA. REV. STAT. ANN. § 40:2202(5) (West 1992).

[10]Section 2202(3) of the Act reads:

"Group purchaser" shall mean an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization. "Group purchaser" may include:

(a) Entities which contract for the benefit of their insured [sic], employees, or members such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs.

(b) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers, or other intermediaries. *See* LA. REV. STAT. ANN. § 40:2202(3) (West 1992).

insured, employees, or member's[11]; and "[e]ntities which serve as brokers for the formation of [contracts with providers], including health care financiers, third party administrators,...or other intermediaries."[12]

The Any Willing Provider statute, which is incorporated as § 2202(5)(c) of the Act, mandates that "[n]o licensed provider...who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider."[13] According to an advisory opinion issued by the Louisiana Attorney General's office in February 1993, the arbitrary exclusion from a PPO of a licensed physician who is "willing and able to accede to the terms and conditions of the preferred provider contract" constitutes both a violation of the Any Willing Provider statute and an unfair trade practice under Louisiana law.[14]

2. The Parties

Both CIGNA and CGLIC constitute "group purchasers" under the terms of the Act. CIGNA is a licensed health maintenance organization (HMO) that provides prepaid health care coverage to enrolled subscribers—including the sponsors of ERISA-qualified employee benefit plans—by contracting with selected physicians, hospitals, and other health care suppliers (collectively, providers). The chosen providers agree to comply with CIGNA's quality control requirements and to offer health care services to CIGNA's subscribers at a discounted rate.

In Louisiana, CIGNA's provider network is marketed by CGLIC, a licensed health insurer. CGLIC also contracts with CIGNA for the right to use the provider network in conjunction with the insured and self-funded health benefit plans that CGLIC offers to, and administers for, its clients. Like CIGNA's subscribers, CGLIC's clients include the sponsors of ERISA-qualified employee welfare benefit plans.

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[11]LA. REV. STAT. ANN. § 40:2202(3)(a).

[12]LA. REV. STAT. ANN. § 40:2202(3)(b).

[13]LA. REV. STAT. PNN. § 40:2202(5)(c).

[14]*See* Op. Att'y Gen. No. 92-824 (Feb. 8, 1993).

3. Impact of the Any Willing Provider Statute

In 1994, CIGNA notified one of the physicians on its provider network, Dr. Ronald Sylvest, that his contract was being terminated. Dr. Sylvest sued CIGNA, alleging that his termination violated the Any Willing Provider statute. After a temporary restraining order was issued against CIGNA, the parties reached a settlement; and the suit was dismissed.

Since the dismissal of the Sylvest suit, CIGNA has received statutory notice from the Attorney General's office that a formal complaint has been filed by a doctor charging that CIGNA violated the Any Willing Provider statute by rejecting his application to its provider panel. Moreover, CIGNA has received, and would like to reject, applications from a number of physicians seeking inclusion in its network of providers.

B. PROCEEDINGS

In an effort to free themselves from the threat of suit for the violation of the Any Willing Provider statute, CIGNA and CGLIC brought this action against Ieyoub in federal district court, seeking *inter alia* (l) a declaratory judgment holding that the Any Willing Provider statute is preempted by ERISA; and (2) an injunction prohibiting the commencement of any action against them for alleged violations of the Any Willing Provider statute. The district court granted summary judgment declaring that ERISA preempts the Any Willing Provider Statute insofar as it relates to third party administrators and health care plans that provide services to ERISA-qualified benefit plans, and issued an injunction barring Ieyoub from enforcing the statute against CIGNA and CGLIC. Ieyoub timely appealed.

II. ANALYSIS

A. STANDARD OF REVIEW

When reviewing a grant of summary judgment, we view the facts and inferences in the light most favorable to the non-moving party[15]; and we apply the same standards as those governing

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[15]*See Cavallini v. State Farm Mut. Auto Ins. Co.*, 44 F.3d 256, 266 (5th. Cir. 1995).

the trial court in its determination.[16] Summary judgment must be granted if a court determines "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."[17]

B. ERISA PREEMPTION[18]

1. Preemption Doctrine

The first question we must address is whether the Any Willing Provider statute is preempted pursuant to § 514(a) of ERISA. Section 514(a) states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" that is covered by the federal statute.[19] Courts have interpreted this preemption clause broadly, observing that its deliberatively expansive language was designed "to establish...plan regulation as exclusively a federal concern."[20]

The Supreme Court has given the phrase "relate to" a "broad common-sense meaning."[21] A state law relates to an ERISA plan "in the normal sense of the phrase if it has connection with or reference to such a plan."[22] A state law can relate to an ERISA plan even if that law was not specifically designed to

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[16]*See Neff v. Am. Dairy Queen Corp.*, 58 F.3d 1063, 1065 (5th. Cir. 1995), *cert. denied*, 116 S. Ct. 704 (1996).

[17]FED. R. CIV. P. 56(c).

[18]Ieyoub contends that we may not address the substantive issues of this case, as CIGNA and CGLIC lack standing and no active justiciable controversy exists. We agree with the district court's conclusion that these arguments are meritless, and we approve the reasoning set forth in the court's opinion. *See CIGNA Healthplan of Louisiana Inc. v. State of Louisiana. ex rel. Richard P. Ieyoub*, 883 F. Supp. 94 (M. D. La. 1995).

[19]*See* 29 U.S.C.S. § 1144(a).

[20]*Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990) (internal quotations and citations omitted).

[21]*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987).

[22]*Shaw*, 463 U.S. at 96-97 (emphasis added).

affect such plans, and even if its effect is only indirect.[23] *If a state* law does not expressly concern employee benefit plans, it will still be preempted insofar as it applies to benefit plans in particular cases.[24] Of particular significance to our analysis today is the fact that the Supreme Court has repeatedly held that ERISA preempts "state laws that mandat[e] employee benefit structures or their administration."[25]

Nevertheless, ERISA preemption is not without limits. The Supreme Court has cautioned that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[26] A unanimous Supreme Court has recently held in this regard that ERISA does not preempt state laws that have "only an *indirect economic effect* on the relative costs of various health insurance packages" available to ERISA-qualified plans.[27]

ERISA itself contains provisions which limit the scope of preemption.[28] For the purposes of the instant appeal, it is relevant that under § 514(b)(2)(A) of ERISA, preemption stops short of "any law of any State which regulates insurance."[29]

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[23]*See Rozzell v. Security Services. Inc.*, 38 F.3d 819, 821 (5th. Cir. 1994) (citing *Pilot Life*, 481 U.S. 41).

[24]*See Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enter. Inc.*, 793 F.2d 1456 (5th. Cir. 1986), *cert. denied*, 479 U.S. 1034, *and cert. denied*, 479 U.S. 1089 (1987).

[25]*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1678, 131 L. Ed. 2d 695 (1995) [hereinafter *Travelers*] (citing *Shaw*, 463 U.S. 85; *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 US. 504, 101 S. Ct. 1895, 68 L. Ed. 2d 402 (1981)).

[26]*Shaw*, 403 U.S. at 100 n.21.

[27]*Travelers*, 115 S. Ct. at 1680 (discussing New York statute requiring hospitals to collect surcharges from patients covered by commercial insurers but not from patients insured by a Blue Cross/Blue Shield plan) (emphasis added).

[28]*See* 29 U.S.C.S. § 1144(b) (Law. Co-op 1990 & Supp. 1995).

[29]*See* 29 U.S.C.S. § 1144(b)(2)(A); *see also Travelers*, 115 5. Ct. at 1675.

2. Application of § 514(a) to the Instant Appeal

As discussed above, § 514(a) of ERISA provides for the preemption of state laws that either refer to or have a connection with an ERISA-qualified plan.[30] The Any Willing Provider statute qualifies for preemption on both counts. First, it refers to ERISA-qualified plans. More specifically, the statute requires that all licensed providers "who agre[e] to the terms and conditions of the preferred provider contract" must be accepted as providers in the PPO.[31] Under the terms of the Act, a preferred provider contract constitutes an agreement "between a provider or providers and *a group purchaser or purchasers* to provide for alternative rates of payment specified in advance for a defined period of time."[32] The Act specifically provides that group purchasers may include entities, such as "Taft-Hartley trusts or employers who establish or participate in self funded trusts or programs,"[33] which "contract [with health care providers] for the benefit of their . . . employees."[34] Given that these enumerated entities constitute ERISA-qualified plans,[35] the Act, and through it the Any Willing

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[30]*See e.q., Travelers*, 115 S. Ct. at 1677; *Dist. of Columbia v. Greater Washington Bd of Trade*, 506 U.S. 125, 113 5. Ct. 580, 121 L. Ed. 2d 513 (1992); Shaw, 463 U.S. at 96-97.

[31]*See* LA. Rev. STAT. ANN. § 40:2202(5)(C).

[32]*See* LA. REV. STAT. ANN. § 40:2202(5)(a) (emphasis added).

[33]*See* LA. REV. STAT. ANN. § 40:2202(3)(a).

[34]*See id.* ("'Group purchaser' may include:...Entities which contract for the benefit of their insured [sic], *employees*, or members such as insurers, self-funded organizations, *Taft- Hartley trusts*, or *employers who establish or participate in self funded trusts or programs*.") (emphasis added). We note that the statute would be considerably clearer if it had been drafted as follows: "'Group purchaser' may include:...Entities (such as self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs) which contract for the benefit of their insured [sic], employees, or members."

[35]*See* 29 U.S.C.S. § 1002(1)(A) (Law. Co-op 1992) (defining an employee welfare benefit plan as "any plan, fund, or program which...is...maintained by an employer...to the extent that such plan, fund, or program...is maintained for the purpose of providing for its participants...medical...care or benefits ..."); *see also* 29 U.S.C.S. § 1002(1)(B) (Law. Co-op 1992) (including in the definition of employee welfare benefit plans programs providing "any benefit described

Provider statute,[36] expressly refers to ERISA plans.

Moreover, the statute "relates to" ERISA plans in the sense that it is connected with such plans. The Supreme Court has emphasized that preemption is appropriate on this ground when statutes "mandat[e] employee benefit structures or their administration."[37] In the instant case, ERISA plans that choose to offer coverage by PPOs are limited by the statute to using PPOs of a certain structure—i.e., a structure that includes every willing, licensed provider. Stated another way, the statute prohibits those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider. As such, the statute connects with ERISA plans.

Neither is it of any consequence that plans might not choose to offer coverage by PPOs: It is sufficient for preemption purposes that the statute eliminates the choice of one method of structuring benefits.[38] The fact that neither CIGNA nor CGLIC is itself an ERISA plan is likewise inconsequential: By denying insurers, employers, and HMOs the right to structure their benefits in a particular manner, the statute is effectively requiring ERISA plans to purchase benefits of a particular structure when they

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in section 302(c) of the Labor Management Relations Act"). The referenced section of the Labor Management Relations Act provides for the establishment of Taft-Hartley trusts. *See* 29 U.S.C.S. § 186(c) (Law. Co-op 1993); *Lickteig v. Business Men's Assurance Co. of Am.*, 61 F.3d 579, 581 n.3 (8th Cir. 1995).

[36]We recognize that in holding that the statute refers to ERISA plans, we rely heavily on language that is found not in the text of the statute itself, but rather in the surrounding provisions of the Act that define the key terms of the statute. As these provisions are indispensable to the interpretation and application of the statute, we cannot separate the references to ERISA in those provisions from such references in the statute itself.

[37]*See Travelers*, 115 S. Ct. at 1678.

[38]*See, e.g., Alessi*, 451 at 524 (discussing a state statute that banned pension benefit offsets based on workers compensation awards, and holding that the statute related to ERISA plans pursuant to § 514(a) because it "eliminate[d] one method for calculating . . . benefits . . . that is permitted by federal law"); *see also FMC Corp.*, 498 U.S. at 60 (holding that statute related to ERISA plans pursuant to § 514(a) because it "prohibit[ed] plans from being structured in a manner requiring reimbursement in the event of a recovery from a third party").

contract with organizations like CIGNA and CGLIC.[39] In that regard, the statute "bears indirectly but substantially on all insured plans,"[40] and is accordingly preempted by ERISA.[41] Ieyoub and amici curiae[42] strenuously argue that this conclusion is barred by the Supreme Court's recent decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,[43] which was decided shortly after the district court issued its opinion in the instant case. In *Travelers*, the Court held that ERISA does not preempt a New York statute that requires hospitals to collect surcharges from patients covered by commercial insurers, but not from patients insured by Blue Cross & Blue Shield plans. The plaintiffs in *Travelers* argued that the New York statute was preempted by ERISA because it "make[s] the Blues more attractive (or less unattractive) as insurance alternatives and thus ha[s] an *indirect economic effect* on choices made by insurance buyers, including ERISA plans."[44] The Supreme Court disagreed, holding

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[39]*See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 5. Ct. 2380, 85 L. Ed. 2d 728 (1985) (holding that a statute "relates to" ERISA plans for the purposes of preemption if it "requires [the plans] to purchase the . . . benefits specified in the statute when they purchase a certain kind of common insurance policy.").

[40]*See Metropolitan Life*, 471 U.S. at 739.

[41]*Cf. Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir.) (holding that Virginia statute prohibiting insurance companies from unreasonably discriminating in establishing PPOs is covered by ERISA's preemption provision because it "restricts the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit plan to those preferred by the insurer") (also holding that the statute was saved from preemption by ERISA's insurance savings clause), cert. *denied*, 114 5. Ct. 579 (1993); *Blue Cross and Blue Shield of Atlanta v. Nielsen*, No. CV-94-L-1265-S, 1996 U.S. Dist. LEXIS 1970 (Jan. 31, 1996) (holding that Alabama's equivalent of the Any Willing Provider statute is preempted by ERISA).

[42]A brief was filed in support of Ieyoub's position by the Louisiana State Medical Society and the Louisiana Dental Association acting as amici curiae.

[43]115 S. Ct. 1671.

[44]*See id.* at 1679 (emphasis added).

that statutes that have "only an indirect economic effect on the relative costs of various health insurance packages"[45] available to ERISA plans are not preempted by ERISA. The Court reasoned that "[a]n indirect economic influence...does not bind plan administrators to any particular choice."[46] The Court also emphasized the limited nature of its holding:

> [W]e do not hold today that ERISA preempts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage...and that such a state law might indeed be preempted under § 514. But as we have shown, New York's surcharges do not fall into [that] category; *they affect only indirectly the prices of insurance policies*, a result no different from myriad state laws in areas traditionally subject to local regulation...[47]

Unlike the New York statute at issue in *Travelers*, Louisiana's Any Willing Provider statute specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure. As such, the statute falls outside the purview of the limited *Travelers* holding: The Court there repeatedly recognized that ERISA preempts "state laws that mandat[e] employee benefit structures."[48] Accordingly, we hold that the *Travelers* decision leaves undisturbed our conclusion that Louisiana's Any Willing Provider statute is preempted by ERISA.

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[45] *Id.* at 1680.

[46] *Id.*

[47] *Id.* at 1683 (emphasis added) (citations omitted).

[48] *Id.* at 1678; *see also id.* at 1679 (distinguishing New York law from preempted laws on ground that it "does not bind plan administrators to any particular choice"); *id.* at 1681.

3. The Insurance Exception

Determining that the Louisiana statute "relates to" ERISA plans and is therefore covered by ERISA's broad preemption provision does not complete our inquiry. We must next consider whether the statute is nonetheless saved from preemption by one of the exceptions embodied in ERISA's savings clause. This clause provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking, or securities."[49] In *Metropolitan Life Insurance Co. v. Massachusetts*,[50] the Supreme Court delineated the requirements that a statute must meet to come within the insurance facet of the savings clause. As we have noted in prior opinions, the Court took a conjunctive two-step approach:

> First, the court determined whether the statute in question fitted the common sense definition of insurance regulation. Second, it looked at three factors: (1) Whether the practice (the statute) has the effect of spreading the policyholders' risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. If the statute fitted the common sense definition of insurance regulation *and* the court answered "yes" to *each* of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.[51]

Thus, if a statute fails either to fit the common sense definition of insurance regulation or to satisfy any one element of the three-factor *Metropolitan Life* test, then the statute is not exempt from preemption by the ERISA insurance savings clause.[52]

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[49]29 U.S.C.S. § 1144(b)(2)(A) (emphasis added).

[50]471 U.S. 724.

[51]*Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993) (citations omitted) (emphasis added); *See also NGS Am., Inc. v. Barnes*, 998 F.2d 296, 299 (5th Cir. 1993).

[52]*See Tingle*, 996 F.2d at 108; NGS Am., 998 F.2d at 299.

When we begin to apply that test to Louisiana's Any Willing Provider Statute, we may start and finish with the third factor of the *Metropolitan Life* test: On its face, Louisiana's statute obviously is not "limited to entities within the insurance industry." Even though the statute lists insurers as one group covered by its terms, it also specifies, in a non-exclusive list, that it applies to "self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs,"[53] as well as "health care financiers, third party administrators, providers, or other intermediaries."[54] As the statute fails to meet the third factor of the *Metropolitan Life* test,[55] we affirm the district court's holding that the statute is not saved from preemption by the insurance exception of § 514(b) of ERISA.

III. CONCLUSION

For the foregoing reasons, we affirm the district court's grant of summary judgment declaring that ERISA preempts the Any Willing Provider Statute insofar as it relates to third party administrators and health care plans that provide services to ERISA-qualified benefit plans. We also affirm the court's grant of an injunction barring Ieyoub from enforcing the statute against CIGNA and CGLIC.

AFFIRMED.

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[53]LA. REV. STAT. ANN. 40:2202(3)(a).

[54]LA. REV. STAT. ANN. 40:2202(3)(b).

[55]*See Iron Workers Mid-South Pension Fund v. Terotechnology Corp.*, 891 F.2d 548 (5th Cir.), *cert. denied*, 497 U.S. 1924 (1990). As discussed above, having determined that the statute fails to meet one element of the *Metropolitan Life* test, we need not consider whether the statute meets the other elements.

APPENDIX C

[Filed May 4, 1995]

United States District Court
Middle District of Louisiana

No. 94-885

CIGNA HEALTHPLAN OF LOUISIANA, INC.
CONNECTICUT GENERAL LIFE INSURANCE COMPANY,
Plaintiffs

v.

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB,
ATTORNEY GENERAL,
Defendant

JUDGMENT AND ORDER OF INJUNCTION

For the reasons stated in this Court's Order and Reasons entered on April 17, 1995, this Court hereby enters the following final judgment and order of injunction.

It is hereby **ORDERED, ADJUDGED AND DECREED** that:

1. Judgment is entered in favor of the plaintiffs and against the defendant on Count I of plaintiffs' complaint at defendant's cost.

2. Judgment is entered dismissing Count II of plaintiff's complaint.

3. Louisiana Revised Statues 40:2202(5)(c), as applied to health care service plans serving participants and beneficiaries of ERISA-regulated employee welfare benefit plans, is declared pre-empted by ERISA and thus violative of the Supremacy Clause of the U.S. Constitution, Art. VI, cl 2.

4. Richard P. Ieyoub, in his official capacity as the Attorney General of Louisiana, and his officers, agents, servants, employees, attorneys, or any of them, and all persons acting in concert or participation with the defendant, are permanently enjoined:

(a) from bringing suit against plaintiffs for alleged violations of Louisiana Revised Statutes 40:2202(5)(c);

(b) from issuing additional "Notice of R.S. 51:1401 Complaint" letters to plaintiffs, following complaints to the Attorney General from health care providers whose applications to become members of plaintiffs preferred provider networks are rejected based on criteria other than the providers' ability and willingness to meet the terms and conditions of these networks;

(c) from applying advisory opinion No. 92-824, as issued on February 8, 1993, to plaintiffs.

New Orleans, Louisiana, this 27th day of April, 1995.

s/ Martin L.C. Feldman
United States District Judge

APPENDIX D

[Filed April 17, 1995]

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF LOUISIANA

No. 94-885

CIGNA HEALTHPLAN OF LOUISIANA, INC.
CONNECTCUT GENERAL LIFE INSURANCE COMPANY
Plaintiffs

versus

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB,
ATTORNEY GENERAL
Defendant

ORDER AND REASONS

Two contradictory motions are before the Court: defendant's motion to dismiss and plaintiffs' motion for partial summary judgment. They explore some new issues of law. For the reasons that follow, defendant's motion is GRANTED in part and DENIED in part and plaintiffs' motion is GRANTED.

Background

Plaintiffs, CIGNA Healthplan of Louisiana, Inc. ("CIGNA") and Connecticut General Life Insurance Company ("CGLIC"), have sued Richard P. Ieyoub, in his official capacity as the Attorney General of the State of Louisiana, for a declaratory judgment concerning § 40:2202(5)(c) of the Louisiana Revised Statutes, the "Any Willing Provider Statute." In Count I, plaintiffs seek a declaratory judgment that, at least as applied to health care service plans that serve participants and beneficiaries of employee welfare benefit plans regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), the Any Willing Provider Statute is preempted by ERISA and thus violates the Supremacy Clause of the United States Constitution, art. VI, cl. 2. As an alternative claim, in Count II plaintiffs seek a declaratory judgment that the statute

violates the Due Process Clause of the Fourteenth Amendment of the Constitution because it interferes with the plaintiffs' freedom to contract with health care providers of their choice. Plaintiffs also seek an order enjoining the State from suing the plaintiffs for violations of the statute and from providing the statutory notification that would enable private parties to obtain treble damages in a civil suit brought under Louisiana Revised Statutes § 51:1409(A), the Unfair Trade Practices and Consumer Protection Law.

CIGNA and CGLIC offer a variety of health care coverages and administrative services to health care consumers through their managed care programs. Under the Any Willing Provider Statute, they are "group purchasers" who serve as brokers and third party administrators of such programs. CIGNA is a licensed HMO and provides prepaid health care coverage to its enrolled subscribers through a network of selectively contracted health care providers, such as physicians and hospitals. CIGNA markets its predetermined cost provider panel to health care consumers, either directly or through employers, insurance companies, or other groups, who are given economic incentives to patronize its network of preferred providers.

By contract, CGLIC markets the CIGNA network to consumers in Louisiana. CGLIC, a duly licensed health insurer, offers and administers both insured and self-funded health benefit plans to its clients, including sponsors of ERISA-regulated employee welfare benefit plans. CGLIC encourages the participants and beneficiaries of its health benefit plans to utilize the services of the CIGNA network through such incentives as coinsurance differentials. These insured and self-funded plans are "preferred provider organizations" ("PPO"s) within the meaning of Louisiana Revised Statute § 40:2202(5)(a). Among the subscribers to CIGNA's and CGLIC's programs are employee benefit plans with HMO or PPO options.

CIGNA and CGLIC compete with many other managed care firms to contract with hospitals and doctors throughout Louisiana for the delivery of health care services to its participants and beneficiaries. Those who participate in the preferred provider network are able to reduce their fees for services

because the limited size of the network insures each provider a sufficient volume of patients to warrant the fee reductions. The preferred provider network also reduces costs and is said to improve services by fostering competition between providers. According to plaintiffs, this selective contracting is what enables them, as well as the employee benefit plans they serve, to control or reduce costs and assure quality.

The plaintiffs claim that their ability to continue to offer services through high quality and low cost HMOs and PPOs in Louisiana is threatened by the Any Willing Provider Statute. In 1984 the statute became effective; it authorizes the formation of preferred provider organizations to assist in reducing health care costs in Louisiana. § 40:2201(C). The statute states: "No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health care services within the limits of his license." § 40:220(5)(c). The plaintiffs maintain that the statute requires them, and as such, employee benefit plans that use their network, to add any health care provider who is willing and able to meet the terms and conditions of their provider contracts.

In February 1993 the Louisiana Attorney General issued Advisory Opinion Number 92-824, which stated his opinion that the violation of the Any Willing Provider Statute would be considered an unlawful trade practice giving rise to a private cause of action under the Unfair Trade Practices and Consumer Protection Law, La. Rev. Stat. Ann. § 51:1405(A) (West 1987). Subsequently, in January 1994, Dr. Ronald D. Sylvest, a health care provider on CIGNA's preferred provider panel, was notified that his services were no longer needed and that (pursuant to a termination clause) his contract with CIGNA would be terminated, effective early March 1994. Dr. Sylvest sued CIGNA, alleging that CIGNA violated the Any Willing Provider Statute by terminating his participation on the panel. A temporary restraining order was issued against CIGNA, but the suit was subsequently dismissed after a settlement was reached. CIGNA notes that at the point of settlement, it had already incurred substantial legal expenses in its defense.

In May and July 1994, Drs. Neil Smith and John Saer submitted applications for admission to CIGNA's preferred provider panel. Because CIGNA had already contracted to place a number of other doctors of Dr. Smith's and Dr. Saer's specialties on its panel, CIGNA rejected their applications. CIGNA is currently processing more applications from other doctors in Louisiana for admission to its panel. CIGNA wishes to exclude some of these applicants because enough doctors in the relevant specialties have already been signed up.

Also, in May 1994 the Attorney General mailed a "Notice of R.S. 51:1401 Complaint" to plaintiffs. The statutory notice informed them that a formal complaint had been filed with the Attorney General's office by another doctor, Dr. Stephen Anthony Scalco, charging that the plaintiffs had violated the Unfair Trade Practices and Consumer Protection Law by rejecting his panel application in violation of the Any Willing Provider Statute. The notice further warned that if the rejection was found to violate the statute and constitute an unfair trade practice under the Unfair Trade Practices and Consumer Protection Law, Dr. Scalco would be entitled to treble damages.

To engage their request for declaratory relief, plaintiffs allege that this series of events makes them vulnerable to additional or immediate suit for violation of the Any Willing Provider Statute. They note that such suits will force them to incur still more costly legal expenses as well as cause harm to their reputation among consumers. Because the Unfair Trade Practices and Consumer Protection Law may also be enforced by the Attorney General under La. Rev. Stat. Ann. § 51:1407 (West 1987), plaintiffs claim to bear a substantial risk of suit by the Attorney General to enforce the provisions of the Any Willing Provider Statute.

The State has moved for dismissal of both counts of plaintiffs' complaint, asserting a number of defenses in bar. Plaintiffs have responded with a motion for partial summary judgment as to Count I of their complaint, seeking injunctive relief and a declaratory judgment that the Any Willing Provider Statute is preempted by ERISA on the ground that the statute represents the improper extension of state law into an area exclusively reg-

ulated by ERISA.[1] The Louisiana State Medical Society and the Louisiana Dental Association have filed amici curiae papers in support of the State's position.

I. Motion to Dismiss

The Court will consider each of the State's grounds for dismissal in turn.[2]

A. Subject Matter Jurisdiction

1. Federal Question Jurisdiction

a. ERISA Preemption Claim

The State contends that this Court has no subject matter jurisdiction over plaintiffs' ERISA preemption claim because plaintiffs are not enumerated parties entitled to bring a civil enforcement action under ERISA. *See* 29 U.S.C. § 1132(a). The plaintiffs respond that the Court has federal question jurisdiction under 28 U.S.C. § 1331 because they claim that the Any Willing Provider Statute violates the Supremacy Clause of the United States Constitution by virtue of ERISA's broad preemption sweep. *See* 29 U.S.C. § 1144. The Court must determine whether § 1331 provides plaintiffs their ticket to a seat in federal court. The Court concludes that it does.

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[1]Plaintiffs urge that the Any Willing Provider Statute "affects employee benefit plans utilizing HMO and PPO coverages by altering their administration, eroding the quality of health care services which they provide[,] and increasing the costs of such plans for employers and their employees in Louisiana."

[2]Because the State's defenses under the Eleventh Amendment and the Anti-Injunction Act are patently without merit, the Court only summarily addresses them here. First, the State claims that it is immune from suit under the Eleventh Amendment. Clearly, the State is not entitled to such a defense under these circumstances.

See Ex Parte Young, 28 S.Ct. 441 (1908); *Edelman v. Jordan*, 94 S.Ct. 1347 (1974). *See also Jones v. Louisiana ex rel. Bd. of Trustees*, 764 F.2d 1183, 1185-86 (5th Cir. 1985) (although state official not named in caption, named in body of complaint and thus Eleventh Amendment defense meritless). Secondly, the State maintains that the Anti-Injunction Act effectively bars plaintiffs' suit. However, plaintiffs plainly do not seek to stay any current or pending state court proceedings. *See Dombrowski v. Pfister*, 85 S.Ct. 1116 (1965); *B & A Pipeline Co. v. Dorney*, 904 F.2d 996 (5th Cir. 1990). Thus, both defenses are without merit.

In *Shaw v. Delta Air Lines. Inc.*, 103 S.Ct. 2890 (1983), plaintiffs, employers and a plan sponsor, claimed that a state law was preempted by ERISA. The Supreme Court held that the federal court indeed had subject matter jurisdiction over plaintiffs' suit and noted that

> [i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. A plaintiff who seeks injunctive relief from state regulation on the ground that such regulation is preempted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.

Id. at 2899 n.14 (citations omitted). Although the State invokes the Supreme Court's decision in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 103 S.Ct. 2841 (1983) in support of its argument that the plaintiffs' assertion of ERISA preemption does not give rise to federal jurisdiction[3], the Supreme Court explicitly held in *Shaw* that *Franchise Tax Board* did not call into question the federal court's jurisdiction to decide cases seek-

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[3]The State also attempts to use two Louisiana federal district court decisions. Both are equally inapplicable because they involved attempts by defendants to remove to federal court on the *defense* of ERISA preemption and neither involved a suit for declaratory or injunctive relief against the State. In *Gavin North Sherwood Chiropractic Clinic, A.P.C. v. Brouer*, 838 F. Supp. 274 (M.D. La. 1993), an association of chiropractic clinics brought suit in Louisiana state court against a preferred provider organization to be admitted as preferred providers. *Id.* at 275. The plaintiffs alleged a violation of the Any Willing Provider Statute. When the defendants attempted to remove to federal court claiming ERISA preemption, the Court ordered the case remanded to state court for lack of subject matter jurisdiction. *Id.* at 276. In *Willis-Knighton Medical Center v. Community Health Network of Louisiana. Inc.*, Civ. A. No. 93-1503, slip op. at 3 (W.D. La. Dec. 16, 1993), plaintiffs, a hospital and numerous physicians, sued an HMO in Louisiana state court for breach of contract. The plaintiffs expressly did not allege a violation of the Any Willing Provider Statute and in fact no mention of the statute is made in the opinion. *Id.* at 9-10. When the defendant attempted to remove to federal court claiming that plaintiffs' breach of contract claim was preempted by ERISA, the Sherman Act and the Clayton Act, the Court ordered the case remanded to state court for lack of subject matter jurisdiction.

ing injunctive and declaratory relief on ERISA preemption grounds. *Shaw*, 103 S.Ct. at 2899 n.14.

Moreover, a recent Fifth Circuit decision expressly supports the plaintiffs' position that this Court can properly exercise its subject matter jurisdiction. In *Self-Insurance Institute of America. Inc. v. Korioth*, 993 F.2d 479 (5th Cir. 1993), the court held that subject matter jurisdiction exists under § 1331 when a party seeks both declaratory and injunctive relief based upon the contention that a state law violates the Supremacy Clause by virtue of ERISA preemption, even when the plaintiffs are nonenumerated ERISA parties who could not sue under ERISA's civil enforcement provision. *Id.* The court commented that "a federal declaratory judgment action affirmatively brought to determine whether a state law is preempted presents a valid basis for federal question jurisdiction." *Id.* at 483; *see also Hydrostorage. Inc. v. Northern Cal. Boilermakers Local Joint Apprenticeship Comm.*, 891 F.2d 719, 725 (9th Cir. 1989), *cert. denied*, 111 S.Ct. 72 (1990) (court had subject matter jurisdiction under § 1331 over suit for declaratory and injunctive relief brought-by a non-enumerated party to prevent enforcement of a state regulation claimed to be preempted by ERISA). As in *Korioth*, the fact that there is no underlying state court suit involved here makes "the preemption issue . . . particularly amenable to a federal forum." *Id.* at 482. And as did the defendants in *Korioth*, both the State and *amici curaie* here confuse the issue of standing with that of jurisdiction. *See id.* at 483-84.

The State also maintains that plaintiffs' ERISA preemption claim is insubstantial as obviously without merit; it claims that prior decisions foreclose controversy on the subject. *See New Orleans Public Serv.. Inc. v. City of New Orleans*, 782 F.2d 1236, 1241, *withdrawn in part on other grounds*, 798 F.2d 858 (5th Cir. 1986), *cert. denied*, 107 S.Ct. 1910 (1987). In determining the substantiality of plaintiffs' ERISA claim, the Court must keep in mind the rigorous test for dismissal. And the Court may not dismiss "if there is 'any foundation of plausibility to the claim." *Id.* (quoting *Meason v. Bank of Miami*, 652 F.2d 542, 547 (5th Cir. 1981), *cert. denied*, 102 S.Ct. 1428 (1982)). The Court need not conclude that the plaintiffs will ultimately prevail on their claim. *NOPSI*, 782 F.2d at 1242. As this preempting question is a matter of first impression, the Court

cannot conclude that plaintiffs' claims are clearly without merit or foreclosed by precedent.

b. Due Process Claim

In Count II of their complaint, plaintiffs assert a Fourteenth Amendment due process claim. The Due Process Clause provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. Plaintiffs have pleaded they should have the "liberty...to contract with providers of their choice to establish and maintain an economically viable preferred provider arrangement pursuant to [the Any Willing Provider Statute]." (Pls.' Compl. 34). They maintain that, on the contrary, such liberty is impeded by the Any Willing Provider Statute. Because the plaintiffs expressly set forth a claim under the Constitution, their claim necessarily arises under federal law for purposes of § 1331. *See, e.g., Powell v. McCormack*, 89 S.Ct. 1944, 1960-61 (1969).

1. Failure to State a Claim

The State's argument concerning plaintiffs' due process claim turns more on the viability of their claim than the Court's power to adjudicate it. Because the State essentially attacks plaintiffs' claim on the merits, the Court will consider whether under Federal Rule of Civil Procedure 12(b)(6), plaintiffs' due process claim states a claim upon which relief may be granted. The Court finds that it does not and thus dismisses Count II of plaintiffs' complaint.

In support of due process relief, plaintiffs argue that the Any Willing Provider Statute is not rationally related to a legitimate state purpose. *See, e.g., Pension Benefit Guar. Corp. v. R.A. Gray & Co.*, 104 S.Ct. 2709 (1984). Rather, they say, the statute forces PPOs to contract with each qualified provider who is willing to participate, thus spreading a limited pool of patients over an unlimited provider pool. They also argue that the net result of compliance with the statute is increased costs for both PPOs and HMOs as well as patients, a result that is in direct contravention with the statute's articulated purpose of providing an "incentive for purchasers and providers to strive for more cost-efficient and effective methods of providing quality patient care and more efficient

payment for services rendered." La. Rev. Stat. Ann. § 40:2201(B) (West 1987). However, even assuming that plaintiffs have a liberty or property interest that deserves protection, an issue the Court does not reach, the Court concludes that the statute is rationally related to the legitimate and asserted State purpose of assuring patient access to quality health care without restricting the freedom to choose one's provider.

2. Case or Controversy[4]

Under both the Declaratory Judgment Act, 28 U.S.C. § 2201 and Article III of the Constitution, the Court may adjudicate a claim for declaratory relief only when an actual controversy exists. *Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 61 S.Ct. 510, 511 (1941). The State denies the existence of a live controversy as to both counts of plaintiffs' complaint and asserts that plaintiffs' claims are based upon mere conjecture as to whether the State will ever file suit against the plaintiffs for a violation of the Any Willing Provider Statute. It also urges that any declaratory judgment would be advisory in nature.

Plaintiffs counter that not only have they been sued by at least one person for violating the statute, but also that the threat of future suits by the State and other persons is beyond mere speculation. Plaintiffs remind us that although the Attorney General has not yet sued them to enforce the statute, he has issued a formal opinion in which he concluded that the statute provides for a private right of action under the Unfair Trade Practices and Consumer Protection Law, *see First Gibraltar Bank. FSB v. Morales*, 19 F.3d 1032, 1038 (5th Cir.), *cert. denied*, 115 S.Ct. 204 (1994), *vacated and superseded on other grounds*, 42 F.3d 895 (5th Cir. 1995), which also accords to the State an enforcement mechanism of its own. La. Rev. Stat. Ann. § 51:1407 (West 1987). The

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[4]Although the State catalogs this issue separately, because the analysis is the same under either theory, the Court will consider concurrently whether an actual case or controversy exists under both the Declaratory Judgment Act and the United States Constitution. *See Texas v. West Publishing Co.*, 882 F.2d 171, 175 (5th Cir. 1989), *cert. denied*, 110 S.Ct. 869 (1990) ("case or controversy requirement of Article II of the . . . Constitution is identical to the actual controversy requirement under the Declaratory Judgment Act".)

Attorney General has also given plaintiffs the statutory notice of a complaint which asserts a claim based upon plaintiffs' violation of the Any Willing Provider Statute because of their denial of a doctor's right to become a network provider. *See* La. Rev. Stat. Ann. § 51:1409(A) (West 1987).

The Court finds that an actual justiciable controversy of sufficient immediacy and reality persists which vests the Court with the discretion to entertain a request for declaratory relief. *See Texas v. West Publishing Co.*, 882 F.2d 171, 175 (5th Cir. 1989), *cert. denied*, 110 S.Ct. 869 (1990). The preemption question presented implicates an issue of law and thus is aptly fit for judicial determination. *First Gibraltar*, 19 F.3d at 1038. Moreover, the plaintiffs ought not be "'placed in the dilemma of incurring the disadvantages of complying [with the statute] or risking penalties for noncompliance.'" *Id.* at 1039 (quoting *Whitney v. Heckler*, 780 F.2d 963, 969 n.6 (11th Cir.), *cert. denied*, 107 S. Ct. 65 (1986)); *see also Babbitt v. United Farm Workers Nat'l Union*, 99 S.Ct. 2301, 2308 (1979).[5]

3. Standing to Bring ERISA Preemption Claim

The substance of the State's standing argument is that plaintiffs' injuries arise from the state statute's requirements, and not from any right inherent in ERISA itself[6], thus depriving plaintiffs of standing. This argument, however, fails to take into account the fact that plaintiffs bring their suit under the Supremacy Clause and the Due Process Clause of the Fourteenth Amendment.

Two recent decisions of the Fifth Circuit undermine the State's argument. First, as discussed earlier, in *Self-Insurance*

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[5]The Court notes that the plaintiffs' risk of suit and the potential incurrence of significant economic losses to both plaintiffs and their subscribers as a result of their compliance with the statute creates a real controversy. If forced to comply with the statute, plaintiffs would suffer significant economic cost as a result of the restructuring of their plan to accommodate all willing providers.

[6]Neither party debates that plaintiffs have no mechanism with which to bring a suit under the civil enforcement action provisions of ERISA. *See* 29 U.S.C. § 1132(a). The case literature, as reflected in *Korioth*, separates the subject matter jurisdiction analysis and the standing analysis. Both, however, implicate related doctrine.

Institute of America. Inc. v. Korioth, 993 F.2d 479 (5th Cir. 1993), the court held that an organization composed of employer sponsors, plan sponsors, and *third party administrators*[7], although not enumerated in ERISA's civil enforcement provision, had standing to bring suit seeking a declaratory judgment and related injunctive relief that a Texas statute was preempted by ERISA. Id. at 484-85. Relying on *Association of Data Processing Services Organizations. Inc. v. Camp*, 90 S.Ct. 827 (1970), the Fifth Circuit concluded (1) that plaintiffs would suffer injury in fact — economic injury — through the statute's enforcement and that such injury would likely be remedied by the court's finding that the statute was preempted by ERISA, and (2) that third-party administrators providing services to ERISA plans fall within ERISA's zone of interest, even if unenumerated therein.[8] *Korioth*, 993 F.2d at 484; *see also* 29 U.S.C. § 1002(14)(A)-(B) (ERISA defines a "party in interest" as a person providing services to employee benefit plans. Here, plaintiffs indisputably provide services to such plans through their HMOs and PPOs). In *NGS American. Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993) ("NGSII"), *aff'g* 805 F. Supp. 462 (W.D. Tex. 1992) ("NGSI"), the court again agreed that a third party administrator of an ERISA plan had standing to seek a declaration against the state that a state statute was preempted by ERISA. *NGSII*, 998 F . 2d at 298 n.2; *see also NGSI*, 805 F. Supp. at 465 (holding that " [e]ven if [a] third-party administrator is not a 'fiduciary' under ERISA, such an administrator still has standing...pursuant to...§ 1331").

In *Lujan v. Defenders of Wildlife*, 112 S.Ct. 2130 (1992), the Supreme Court spoke of three prerequisites of standing:

> First, the plaintiff must have suffered an 'injury in fact' - an invasion of a legally-protected interest which is (a) con-

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[7]The State acknowledges that these plaintiffs are third party administrators and service providers to health benefit plans falling within the scope of ERISA. (*See, e.g.*, Defs.' Mot. to Dismiss at 2-3; Rebuttal Mem. at 6, 8).

[8]The court noted that its finding that third-party administrators fall within the zone of interest was buttressed by the fact that state law defined such administrators as fiduciaries. However, the court did not find this fact decisive to its determination. *See Korioth*, 993 F.2d at 484.

> crete and particularized, and (b) 'actual or imminent, not 'conjectural' or 'hypothetical.'
>
> Second, there must be a causal connection between the injury and the conduct complained of — the injury has to be 'fairly...trace[able] to the challenged action of the defendant, and not...th[e] result [of] the independent action of some third party not before the court.'
>
> Third, it must be 'likely,' as opposed to merely 'speculative,' that the injury will be 'redressed by a favorable decision.'

Id. at 2136 (citations omitted). The burden is on the plaintiffs to establish the existence of these three elements. *Id.*

Plaintiffs meet their burden. Plaintiffs have established sufficient injury.[9] Moreover, there is a connection between the injury and the statute challenged, the Any Willing Provider Statute.[10] Finally, it is likely that, at least to the extent that their programs are aimed at employee benefit plans, the plaintiffs' injury could be redressed by a determination that the Any Willing Provider Statute is preempted by ERISA.

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[9]As in *Korioth*, the plaintiffs here, as discussed above, suffer the injury of economic loss. Contrary to the State's assertion, economic harm has long been considered sufficient palpable injury to give rise to standing. *E.g., O'Hair v. White*, 675 F.2d 680, 687 (5th Cir. 1982). This Court also emphasizes that

> "[w]hen the suit is one challenging the legality of government action or inaction, the nature and extent of facts that must be averred . . . in order to establish standing depends . . . upon whether the plaintiff is himself an object of the action . . . at issue. If he is, there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it."

Lujan, 112 S.Ct. at 2137.

[10]The State mischaracterizes the inquiry by implying that the statute challenged by the plaintiffs is not the Any Willing Provider Statute, but ERISA.

II. ERISA Preemption

A. Standard for Summary Judgment[11]

Federal Rule of Civil Procedure 56 instructs that summary judgment is proper if the record discloses no genuine issue as to any material fact such that the moving party is entitled to judgment as a matter of law. No genuine issue of fact exists if the record taken as a whole could not lead a rational trier of fact to find for the non-moving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 106 S.Ct. 1348 (1986).

B. Application

The Court now turns to the heart of the parties' dispute: whether the statute, as it applies to the employee benefit plans that use the plaintiffs' network of providers, is preempted by ERISA?

1. Relationship of the statute to ERISA

ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a). The Supreme Court has held that the preemption clause "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 111 S.Ct. 403, 407 (1990). The preemption text is notably loose. A state law relates to an employee benefit plan and is thus preempted "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983). A state law may relate to an employee benefit plan and be preempted "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478, 483

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[11]The Court recognizes that the State challenged the preemption issue in their motion to dismiss under Federal Rule of Civil Procedure 12(b)(6). However, because the plaintiffs have filed a motion for partial summary judgment on this issue and neither party places any facts in dispute, thus not impacting the allegations of plaintiffs' complaint, the motions present a pure question of law, the resolution of which would be the same under either procedural vehicle.

(1990). However, although the preemptive scope of ERISA is deliberately expansive, it has its limits. The Supreme Court has cautioned that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n. 21, 103 S.Ct. at 2901 n.21. In applying these principles, the Court bears in mind that the determination of whether ERISA preempts a state law claim turns very much on congressional intent. *See Ingersoll-Rand*, 111 S.Ct. at 482.

Plaintiffs maintain that the Any Willing Provider Statute encounters and confronts ERISA plans for two reasons. They point out that the express terms of the statute seem to cover employee benefit plans. *See FMC Corp.*, 111 S.Ct. at 408 (statute's reference to "[a]ny program, group contract or other arrangement for payment of benefits" was sufficient to establish its relationship to ERISA plans). They also submit that the statute affects the structure and administration of ERISA plans, and therefore necessarily relates to such plans for preemption purposes.[12]

The Court agrees that the statute relates to employee benefit plans. The statute falls within the scope of Louisiana's Health Care Cost Control Act, La. Rev. Stat. Ann. §§ 40:2201-2205 (West 1987 & Supp. 1994), which directs its purpose at reducing health care costs. The language of the Act betrays the State's perception that the statute is no more than a law of general applicability, with no specific reference to ERISA-governed plans. On the contrary, several provisions point to the Act's express reference and applicability to employee benefit plans. The Act defines group purchasers as "[e]ntities which contract for the benefit of their insured, employees, or members such as insurers, self-funded organizations, . . . or employers who establish or participate in self funded trusts or programs [as well as e]ntities which serve as brokers for the formation of such contracts . " La. Rev. Stat. Ann.

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[12]"A state...law may be preempted even though it has no...direct nexus with ERISA plans if its *effect* is to dictate or restrict the choices of ERISA plans with regards to their benefits, structure, reporting and administration." *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179, 1193 (3d Cir.), *cert. denied*, 114 S.Ct. 382 (1993) (emphasis added).

§ 40 :2202 (3) (a) - (b) . The State does not dispute that this definition fits the plaintiffs. In defining the organization of PPOs, the Act expressly recognizes the interests of insureds and employees with its observation that "[t]he contractual...agreements [between the providers and group purchasers, such as plaintiffs here,] may also include incentives which encourage the insured employee or member to utilize the participating providers." La. Rev. Stat. Ann. § 40:2202(5) (b). Finally, the Act explicitly addresses the benefits due participants in plans that incorporate PPO options. *See* La . Rev. Stat . Ann . § 40: 2203 (C) . The statute may well have the effect of expanding the realm of choice of providers while increasing their potential costs, as well as the costs to their employer or plan sponsor. However, potentially increased cost is not the only result of the statute. The Court agrees with the plaintiffs that application of the statute impacts the employers' or plan sponsors' discretion as to how health benefits may be structured under their employee benefit plans. It explicitly directs that they may not structure their programs so as to exclude any provider willing and able to participate. *See Metropolitan Life Ins. Co. v. Massachusetts*, 105 S.Ct. 2380, 2388-89 (1985) (state statute requiring all insured benefit plans to purchase specific benefits when purchasing insurance 'relates to' employee benefit plans); *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir.), *cert. denied*, 114 S.Ct. 579 (1993) (Virginia's 'any willing provider statute' 'relates to' employee benefit plans); *cf. United Wire*, 995 F.2d at 1193 (holding that a statute regulating only hospital rates did not relate to ERISA plans merely because it had the net result of increasing insurers' and self-funded plans' costs of providing benefits).

Having determined that the Any Willing Provider Statute relates to an ERISA plan for purposes of preemption, the Court must next consider whether the statute is nonetheless saved from preemption as a law regulating insurance. *See* 29 U.S.C. § 1144(b)(2)(A).

2. Savings Clause

ERISA's savings clause deals with insurance regulation; it provides that "nothing in this subchapter shall be construed to

exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). It has the effect of "saving" state laws governing the business of insurance from ERISA preemption. *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1552 (1987).

The Fifth Circuit applies a multi-factor test to determine whether a state law falls under the savings clause:

> First, the court determine[s] whether the statute in question fit[s] the common sense definition of insurance regulation. Second, it look[s] at [the] three [McCarran-Ferguson] factors: (l) whether the practice (the statute) has the effect of spreading the policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.

Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 107 (5th Cir. 1993). This Court must first inquire whether the Any Willing Provider Statute meets the common sense definition of insurance regulation.

> A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.

Pilot Life, 107 S.Ct. at 1554. *See also Hayden v. Blue Cross and Blue Shield of Alabama*, 843 F. Supp. 1427, 1434 (M.D. Ala. 1994) (a statute affecting not only the insurance industry, but also other non-insured health care plans and agreements failed the common sense test).

The Court finds that the Any Willing Provider Statute fails the common sense test because it is not specifically directed towards the insurance industry, but, rather, it expressly applies to entities outside the insurance industry, such as employers and Taft-Hartley trusts. *See* La. Rev. Stat. Ann. § 40:2202(3)(a)-(b) (West 1987); *Hayden*, 843 F. Supp. at 1434 ("[a]lthough [the statute at issue there] may have a substantial effect on the insurance industry, the law affects other health care plans and agreements

even though they are not a part of an insurance contract"); *cf. Stuart Circle*, 995 F.2d at 504 (holding that Virginia's statute was expressly limited to entities within the insurance industry).

Because Louisiana's Any Willing Provider Statute fails to meet the common-sense definition of insurance and at least one of the three McCarran-Ferguson factors,[13] the Court finds that the statute does not fall within ERISA's savings clause and is thus preempted to the extent that it relates to employee welfare benefit plans governed by ERISA. *See Tingle*, 996 F.2d at 108.

Accordingly, the defendant's motion to dismiss is DENIED in part and GRANTED in part, and plaintiffs' motion for partial summary judgment is GRANTED.

Plaintiffs are granted summary judgment as to Count I of their complaint. Count II of plaintiffs' complaint is DISMISSED. A Judgment and Order of Injunction that comports with this decision shall be submitted by plaintiffs for execution.

New Orleans, Louisiana, April 11, 1995.

s/ MARTIN L. C. FELDMAN
UNITED STATES DISTRICT JUDGE

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[13]It does not satisfy the third factor because, as previously noted, it is not limited to entities within the insurance industry.

APPENDIX E

CHAPTER 12. HEALTH CARE COST CONTROL

PART I. PREFERRED PROVIDER ORGANIZATIONS

Section

2201. Legislative considerations.
2202. Definitions.
2203. Authorization for Preferred Provider Organizations.
2204. Hospital participation- tangible benefit presumed.
2205. Utilization reviews; relief from liability and discovery; standards compliance.
2206 to 2216. Repealed.

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Acts 1979, No. 449, § 5, effective January 1, 1980, repealed former Chapter 12, which consisted of R.S. 40:2201 to 40:2216 as added by Acts 1964, No. 259, § 1 et seq., pertaining to air pollution control. Act 449, in § 1, also enacted the Louisiana Environmental Affairs Act (R.S. 30:1051 et seq., redesignated as R.S. 30:2001 et seq. and renamed the Louisiana Environmental Quality Act), Part III of which (R.S. 30:1081 et seq., redesignated as R.S. 30:2051 et seq.), the Louisiana Air Control Law, relates to the subject matter of this repealed Chapter. Prior to the repeal, Acts 1978, No. 615, § I had amended R.S. 40:2202 and 40:2204, Acts 1978, No. 786, § 5 had amended R.S. 40:2203 and 40:2204, Acts 1978 No. 383, § I had amended R.S. 40:2204, and Acts 1978, No. 383, § 2 had amended R.S. 40:2212.

PART I. PREFERRED PROVIDER ORGANIZATIONS

§ 2201. Legislative considerations

A. The legislature recognizes that health care costs have risen greatly over the past decade and must be contained without jeopardizing:

(1) The quality of care received by patients.

(2) The ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities and to meet federal and state standards and regulations.

B. The legislature further recognizes that there must be some incentive for purchasers and providers to strive for more cost-efficient and effective methods of providing quality patient care and more efficient payment for services rendered.

C. Therefore, the state can assist in reducing health care costs by authorizing the formation of preferred provider organizations.

D. The legislature further recognizes that the state and governmental bodies can reduce the cost of providing health care benefits for their employees by contracting with a preferred provider organization.

Added by Acts 1984, No. 374, § 1, eff. July 6, 1984.

Historical and Statutory Notes

A prior R.S. 40:2201, part of the former Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § 5. See italic note preceding R.S. 40:2201.

The subsection designations in this section as enacted in 1984 were made pursuant to the statutory revision authority of the Louisiana State Law Institute.

Title of Act:
An Act to enact Chapter 12 of Title 40 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:2201 through 2204; relative to contracts between medical care providers and group purchasers; to authorize preferred provider contracts in Louisiana; to provide for definitions; to provide for authorization for hospital service district hospital participation in such contracts; to provide for physician participation in such contracts; and to provide for related matters. Acts 1984, No. 374.

Cross References

Health and accident insurance generally, see R.S. 22:211 et seq.

WESTLAW Electronic Research

See WESTLAW Research Guide following the Preface.

Notes of Decisions

Bidding 1

1. Bidding
Preferred Provider Organization provides professional services which are not subject to the Public Bid Law. Op.Atty.Gen., No. 90-341, July 24, 1990.

§ 2202. Definitions

As used in this Part, the following definitions shall apply:

(1) "Alternative rates of payment" shall mean the rate at which or sum for which the provider agrees to perform specified services. The rate shall be negotiated between purchaser and provider and shall be in effect for a fixed term. It may, but need not, include a discount from the provider's customary fee.

(2)"Governmental body" means any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or establishment of the executive branch of this state.

(3) "Group purchaser" shall mean an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization. "Group purchaser" may include:

(a) Entities which contract for the benefit of their insured, employees, or members such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs.

(b) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers or other intermediaries.

(4) "Hospital" shall mean any institution, place, building, or agency, public or private, whether for profit or not, including a facility subject to the jurisdiction of a hospital service district, devoted primarily to the maintenance and operation of facilities for ten or more individuals for the diagnosis, treatment, or care of persons admitted for overnight stay or longer who are suffering from illness, injury, infirmity, deformity, or other physical condition for which obstetrical, medical, or surgical services would be available and appropriate. It may also include nursing homes as defined by and regulated under the provisions of R.S. 40:2009.1 through 2009.12.

(5)(a) "Preferred Provider Organization (P.P.O.)" shall mean a contractual agreement or agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment specified in advance for a defined period of time in which

(i) The provider agrees to accept these alternative rates of payment offered by group purchasers to their members whenever a member chooses to use its services and

(ii) There is a tangible benefit to the provider in offering such alternative rates of payment to the group purchaser.

(b) The contractual agreement or agreements may also include incentives which encourage the insured employee or member to utilize the participating providers.

(c) No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his license.

(d) However, nothing in this Part shall be construed to require any hospital to grant any provider or class of providers medical staff membership.

(e) Preferred provider contracts should include, but not be limited to, the following components:

(i) Participating in a resource monitoring component to insure quality control both for patient care and cost effectiveness.

(ii) Procedures to encourage prompt payment for services rendered.

(6) "Provider" shall mean one or more entities which offer health care services and shall include but not be limited to hospitals, individuals or groups of physicians, individuals or groups of psychologists, and other health care entities. Any health care entity which is specifically covered by a group purchaser's insurance policy, employee benefits, self funded organization or Taft-Hartley trust benefits or plan shall be construed to be a "provider" for purposes of consideration under this Part.

(7) "Tangible benefit" shall mean but not be limited to:

(a) Any reasonable expectation of a demonstrable increase in or maintenance of usage of the provider's services.

(b) Contractual provisions requiring quality control of patient care and participation in resource monitoring procedures; or

(c) Any reasonable expectation of prompt payment for services rendered. Added by Acts 1984, No. 374, § 1, eff. July 6, 1984.

Historical and Statutory Notes

A prior R.S. 40:2202, part of the former Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § 5. See italic note preceding R S. 40:2201.

The paragraphs in this section as enacted in 1984 were rearranged in alphabetical order pursuant to the statutory revision authority of the Louisiana State Law Institute.

In the last sentence of par. (1), commas surrounding "but need not" were inserted; in par. (3), at the beginning of the first sentence, "purchaser" was changed from "purchasers" and, at the beginning of the second sentence, "Group purchaser" was surrounded by quotation marks; in par. (5), subparagraph and item designations were inserted and items (a) and (b) in subpars. (5)(a) and (5)(e) were redesignated (i) and (ii); and, in the second sentence of present par. (6), quotation marks enclosing "provider" were inserted, all pursuant to the statutory revision authority of the Louisiana State Law Institute.

Library References

Words and Phrases (Perm.Ed.)

§ 2203. Authorization for Preferred Provider Organizations

A. Any group purchaser may contract with any provider in any contractual agreement or agreements to form a preferred provider organization.

B. Such agreement shall not be construed to authorize a group purchaser to furnish medical services unless the purchaser is otherwise licensed to do so, nor shall such agreement authorize a group purchaser to direct or control the provision or selection of forms or types of medical services to the group members.

C. Group purchaser members participating in preferred provider organizations shall be guaranteed access to their standard benefits under the terms of their policy, employee benefits, self funded organization benefits or Taft-Hartley trust benefits, regardless of whether they choose a preferred provider or a provider who does not participate in the preferred provider contract.

D. Any entity serving as a broker or intermediary under the provisions of R.S. 40:2202(3)(b) who contracts to write or sell insurance shall be subject to

the provisions of Title 22 of the Louisiana Revised Statutes of 1950. However, any entity which serves as a broker or intermediary for the formation of a preferred provider organization for a governmental body shall not be entitled to collect any fee for serving as such broker or intermediary under this Part.

E. Any person requiring emergency medical services shall be entitled to use any available provider without being denied the basic benefits provided under his policy or benefits program.

Added by Acts 1984, No. 374, § 1, eff. July 6, 1984.

Historical and Statutory Notes

A prior R.S. 40:2203, part of the former Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § 5. See italic note preceding R.S. 40:2201.

The paragraphs of this section as enacted in 1984 were rearranged in alphabetical order pursuant to the statutory revision authority of the Louisiana State Law Institute.

Notes of Decisions

Group purchaser 1

1. Group purchaser

Board of Trustees of the State Employees Group Benefit Program has authority to negotiate discount programs with medical providers according to the definition of "group purchaser" in R.S. 40:2203 and the power granted in R.S. 42:874. Op.Atty.Gen., No. 87-831, Jan. 20, 1988.

§ 2204. Hospital participation; tangible benefit presumed

A. Whenever any hospital or governmental body is a party to a preferred provider organization contract, there shall be a rebuttable presumption that such hospital or governmental body contracted with the expectation of receiving a tangible benefit rather than making a donation of services in violation of Section 14(A) of Article VII of the Constitution of Louisiana.

B. Unless clearly indicated otherwise in a preferred provider organization contractual arrangement, it shall be presumed that the hospital, governmental body, or other provider negotiated the contract with the knowledge that such agreement would result in a tangible benefit to the hospital or governmental body and would not constitute a donation of its services to a group purchaser in violation of the Constitution of Louisiana, Article VII, Section 14(A).

C. Whenever a hospital or governmental body is a party to a preferred provider organization contract, the provisions of R.S. 39:1481 et seq. shall not apply.

D. The Board of Trustees of the State Employees Group Benefits Program shall develop criteria governing the state's participation in preferred provider organization contracts which shall be subject to the approval of appropriate standing committees of the legislature having jurisdiction over review of agency rules of the State Employees Group Benefits Program as designated by R.S. 49:968(B)(15) or the subcommittees on oversight of such standing committees, the office of contractual review of the division of administration, and the office of the state treasurer, any of which shall have the authority to approve or disapprove such criteria. Any contract awarded under the provisions of this

Section shall be approved by the Board of Trustees of the State Employees Group Benefits Program.

Added by Acts 1984, No. 374, § 1, eff. July 6, 1984. Amended by Acts 1990, No. 585 § 1, eff. July 19, 1990.

Historical and Statutory Notes

A prior R.S. 40:2204, part of the Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § S. See italic note preceding R.S. 40:2201

The 1990 amendment rewrote subsec- D which had read:

"D. The board of Trustees of the State Employee Group Benefits Program shall develop criteria governing the state's participation in preferred provider organization contracts which shall be subject to the approval of the Joint Committee on the Budget. Any contract awarded under the provisions of this Section shall be approved by the Board of Trustees of the State Employee Group Benefits Program."

§ 2205. Utilization reviews; relief from liability and discovery; standards compliance

Notwithstanding any other provision of law, any health care provider licensed in this state who participates in quality of care or utilization reviews by a peer review committee, as a peer review committee member or a treating health care provider whose patients are subject to such review and have been contracted, employed, or hired by a group purchaser shall be immune from liability for any act performed during such reviews of the activities of similarly licensed health care providers if such person acts without malice, makes a reasonable effort to obtain the facts, and believes that the action taken is warranted by the facts. A peer review committee shall not be subject to discovery, and no person in attendance at such reviews shall be required to testify as to what transpired at such reviews. The utilization review requirements and administrative treatment guidelines of the peer review committee employed or hired by the group purchaser shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider.

Added by Acts 1991, No. 876, § 1.

Historical and Statutory Notes

A prior R.S. 40:2205 was repealed by Acts 1979, No. 449, § 5. See italic note preceding R.S. 40:2201.

§§ 2206 to 2216. Repealed by Acts 1979, No. 449, § 5, eff. Jan. 1,1980

Historical and Statutory Notes

Acts 1979, No. 449, § 5, effective January 1, 1980, repealed former Chapter 12, which consisted of R.S. 40:2201 to 40:2216 as added by Acts 1964, No. 259, § 1 et seq., pertaining to air pollution control. Act 449, in § 1, also enacted the Louisiana Environmental Affairs Act (R.S. 30:1051 et seq., redesignated as R.S. 30:2001 et seq. and renamed the Louisiana Environmental Quality Act), Part III of which (R.S. 30:1081 et seq., redesignated as R.S. 30:205 et seq.), the Louisiana Air Control Law, relates to the subject matter of this repealed Chapter. Prior to the repeal, Acts 1978, No. 615, § 1 had amended R.S. 40:2202 and 40:2204, Acts 1978. No. 786, § 5 had amended R.S. 40:2203 and 40:2204, Acts 1978 No. 383, § 1 had amended R.S. 40:2204, and Acts 1978, No. 383, § 2 had amended R.S. 40:2212.

APPENDIX F

CONSTITUTION OF THE STATE OF LOUISIANA OF 1974

PREAMBLE

We, the people of Louisiana, grateful to Almighty God for the civil, political, economic, and religious liberties we enjoy, and desiring to protect individual rights to life, liberty, and property; afford opportunity for the fullest development of the individual; assure equality of rights; promote the health, safety, education, and welfare of the people; maintain a representative and orderly government; ensure domestic tranquility; provide for the common defense; and secure the blessings of freedom and justice to ourselves and our posterity, do ordain and establish this constitution.

Supreme Court, U.S.
FILED
SEP 30 1996
CLERK

No. 96-316

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB, Attorney General,

Petitioner,

v.

CIGNA HEALTHPLAN OF LOUISIANA, INC. and CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Eleventh Amendment to the Constitution of the United States bars respondents' suit to obtain prospective relief to prevent a state official from violating the Supremacy Clause of the United States Constitution by enforcing a state law that is preempted by a federal statute.

2. Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, preempts a state statute that prohibits employee welfare benefit plans from providing benefits through selective networks of medical providers.

PARTIES TO THE PROCEEDING

Pursuant to Rule 29.6 of the Rules of this Court, respondents state the following: Respondent CIGNA Healthplan of Louisiana, Inc. (now renamed CIGNA HealthCare of Louisiana, Inc.) is a wholly-owned subsidiary of CIGNA Health Corp., which is a wholly-owned subsidiary of Connecticut General Corporation, which is a wholly-owned subsidiary of CIGNA Holdings, Inc., which is a wholly-owned subsidiary of CIGNA Corporation, a publicly held corporation. CIGNA Healthplan of Louisiana, Inc. has no subsidiaries.

Respondent Connecticut General Life Insurance Company is a wholly-owned subsidiary of Connecticut General Corporation, which is a wholly-owned subsidiary of CIGNA Holdings, Inc., which is a wholly-owned subsidiary of CIGNA Corporation, a publicly held corporation. Connecticut General Life Insurance Company has no subsidiaries in which outside persons might have an interest.

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No. 96-316

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB,
Attorney General,

Petitioner,

v.

CIGNA HEALTHPLAN OF LOUISIANA, INC. and
CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI

This Court should deny the petition for *certiorari* to the extent that it presents the question whether the Eleventh Amendment to the Constitution of the United States bars this action. The district court rejected petitioner's assertion of an Eleventh Amendment defense as "patently without merit." (Pet. 23a n.2.) The Court of Appeals agreed with that assessment, finding it "well established that the federal courts have jurisdiction to hear suits against state officials

where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law." (Pet. 3a n.1.) The Court of Appeals also correctly decided that this Court's decision in *Seminole Tribe of Florida v. Florida*, 116 S. Ct. 1114 (1996), did not alter this conclusion. (Pet. 4a n.1.) Because the decision below is squarely supported by this Court's precedent, no reason exists for this Court to review the Eleventh Amendment question.

Although they prevailed below, respondents nonetheless urge this Court to grant the petition for *certiorari* limited to the question of whether Louisiana's "any willing provider" statute is preempted by ERISA. The specific preemption question presented is one that this Court has not addressed and as to which the lower courts are divided. It is of fundamental importance not only to petitioner and officials of other states and to respondents and other entities that offer managed health care coverage, but also to sponsors and participants of ERISA plans that are increasingly subjected to state regulation of the type that ERISA's preemption provision was designed to avoid.

Respondents administer for ERISA-regulated employee benefit plans, many of which operate in multiple states, a network of selectively contracted medical providers, such as physicians. The Louisiana statute at issue directly prohibits respondents and their employee benefit plan customers from using a selective provider network in that state. It provides, both by its express terms and its necessary effect, that an ERISA-covered employee benefit plan or other "group purchaser" may not, regardless of the plan's

provisions, provide health care benefits through a provider network unless that network is open to any and all providers willing to contract on the network's terms and conditions. *See* La. Rev. Stat. Ann. § 40:2202(5)(c) (1992). Although the Court of Appeals correctly held this statute preempted as applied to ERISA-covered employee benefit plans, the pervasive and recurring nature of this question, its nationwide impact, and the conflict in legal analysis among the lower courts warrant the grant of *certiorari*.

ERISA's preemption provision represents a congressional judgment that employee benefit plans should be free to develop their own uniform benefit and administrative structures instead of being subject to a "patchwork scheme of regulation." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). In *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*"), this Court held that a state statute that did not directly regulate ERISA-covered employee benefit plans but merely had the "indirect economic influence" of raising the costs borne by such plans was not preempted by ERISA. The Court left undisturbed, however, its longstanding precedent that ERISA preempts state laws directly affecting the structure and administration of employee benefit plans. Although the court below correctly recognized that *Travelers* had not altered the preemption analysis as to such laws, other courts have reached inconsistent conclusions and results. Review by this Court is necessary to resolve whether a state any willing provider statute that prohibits employee benefit plans from offering benefits through limited provider networks is preempted by ERISA.

Despite the intense public debate over issues of health care costs and delivery, Congress has not modified ERISA's preemptive effect or generally amended ERISA to restrict plan sponsors' freedom in health plan design but has continued "to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as may evolve." *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991). Increasingly, however, state regulation has sought impermissibly to encroach on the operation of employee benefit plans by, among other things, prohibiting or restricting managed care features that are integral to the plans' design. The fact that Louisiana's "any willing provider" statute is one of many such statutes underscores the nationwide scope of the clash between ERISA's protection of the freedom of employee benefit plans to structure their own benefit programs and many states' efforts to restrict that freedom.

Not surprisingly, this conflict between regulatory schemes has already led to substantial litigation that has produced judicial decisions with divergent analyses and results. As the petition notes, the Court of Appeals for the Fourth Circuit has issued a decision reaching a result inconsistent with the decision below and upholding a Virginia any willing provider statute against a challenge based on ERISA preemption. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993). Moreover, some courts have read this Court's decision in *Travelers* as altering the preemption analysis and reopening the question of whether ERISA preempts state laws that directly affect the structure and administration of employee benefit plans. The court

below held that *Travelers* did not affect preemption of the Louisiana statute. The Supreme Court of Connecticut has, however, employed a very different analysis of *Travelers* in concluding that ERISA does not preempt claims that one of respondents' affiliates had violated a state law regulating PPO contracting practices. *See Napoletano v. CIGNA HealthCare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996).

Resolution of the question presented is urgently needed because of its broad and nationwide impact on health care benefits received by the majority of American workers and their families. An estimated 114 million Americans receive health care benefits through employee welfare benefit plans subject to ERISA.[1] In response to the spiraling cost of health care, employers and unions that sponsor such ERISA plans have frequently incorporated "managed care" features into their plan design.[2] In contrast to a traditional fee-for-service or indemnity plan that reimburses all or a portion of the fee charged by a medical service provider, "managed care" seeks to integrate the benefit and delivery aspects of health care so as to provide quality health care at

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[1] *See* U.S. General Accounting Office, Health, Education, and Human Services Div., *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* (GAO/HEHS-95-167) (1995) ("1995 GAO Report") at 2, 45. *See also* Employee Benefit Research Institute Education and Research Fund, *EBRI Databook on Employee Benefits* (3d ed. 1995) at Table 8.8.

[2] *See* U.S. General Accounting Office, Human Resources Div., *Managed Health Care: Effect on Employers' Costs Difficult to Measure* (GAO/HRD-94-3) (1993) ("1993 GAO Report") at 3-4 (discussing the growth of managed care since 1980).

an affordable cost.[3] Among the most frequently used managed care programs are network-based programs, such as preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs") of the type offered by respondents here.[4] So prevalent have these types of programs become that recent statistics show that they are available to upwards of 90 million persons who are participants or beneficiaries in ERISA welfare plans.[5]

Absent review by this Court, litigation over ERISA preemption and any willing provider laws will only increase, and the conflicts among the lower courts will likely only deepen.[6] Without this Court's resolution of the issue,

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[3] *See Arizona v. Maricopa County Med. Soc.*, 457 U.S. 332, 339 n.7 (1982) (discussing the difference between traditional health insurance plans and managed care programs); 1993 GAO Report at 23-31 (discussing key elements of managed care).

[4] *See* 1993 GAO Report at 6-12; *see also* Douglas A. Hastings, *et al.*, eds., *Fundamentals of Health Law* 258-260 (1995).

[5] *See* 1993 GAO Report at 5-7; *see also* 1995 GAO Report at 20 n.39 (reflecting that in 1994, nearly two-thirds of individuals with employer-based insurance were enrolled in network-based managed care).

[6] Legal commentators have also noted the unanswered nature of the question presented here. *See, e.g.*, Jesselyn Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 Yale L. & Pol'y Rev. 339, 380-81 (1995) (discussing uncertainties regarding preemption of any willing provider laws by ERISA); Gary A. Francesconi, *ERISA Preemption of "Any Willing Provider" Laws -- An Essential Step Toward National Health Care Reform*, 73 Wash. U. L.Q. 227 (1995) (same).

employee benefit plans will be free to adopt limited provider networks in some states but not in others, and ERISA's goal of promoting uniform national regulation of such plans will remain elusive. This case presents this important issue in a summary judgment context and on a record of undisputed material facts. Accordingly, respondents urge the Court to grant *certiorari* limited to the question of ERISA preemption.

I. This Court Should Deny Certiorari on the Eleventh Amendment Question

There is no conflict in authority requiring resolution by this Court as to the Eleventh Amendment question presented by petitioner. To the contrary, it is well settled that the Eleventh Amendment does not bar actions to enjoin state officials like petitioner from enforcing state laws that are preempted by federal law. As the district court and the Court of Appeals both held, such actions for prospective relief against state officials have long been allowed under the doctrine established in *Ex parte Young*, 209 U.S. 123 (1908). Just last term, this Court in *Seminole Tribe of Florida v. Florida*, 116 S. Ct. 1114, 1131 n.16 (1996), affirmed the vitality of this doctrine in cases like this one, stating that "an individual may obtain injunctive relief under *Ex parte Young* in order to remedy a state officer's ongoing violation of federal law."

In *Ex parte Young*, the Court held that the Eleventh Amendment does not bar suits against state officers to enjoin them from violating federal law, reasoning that a state officer who (as here) seeks to enforce an unconstitutional

statute is stripped of his official or representative character. 209 U.S. at 159-60; *see also Scheuer v. Rhodes*, 416 U.S. 232, 237 (1974). Following *Ex parte Young*, federal courts have routinely entertained suits against state officials seeking prospectively to prevent those officials from enforcing state laws that violate the Supremacy Clause of the Constitution. Most notably, the Court unanimously applied this rule to ERISA preemption suits in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). There, the Court held that the *Ex parte Young* doctrine empowered plaintiffs to sue to enjoin state regulation that was preempted by ERISA, stating that "[i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights." *Id.* at 96 n.14.[7]

Contrary to petitioner's argument that this case is "dissimilar[ ]" from cases involving "traditional *Ex parte Young* analysis," Pet. 25, this is precisely the type of action encompassed by the *Ex parte Young* doctrine. Respondents sued the Attorney General of Louisiana, who is responsible for enforcing the any willing provider law,[8] and who was

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[7] As *Shaw* makes clear, petitioner is plainly wrong in his contention that *Ex parte Young* applies only if the state official seeks to enforce "a criminal statute with intimidating provisions and penalties." (*See* Pet. 27.)

[8] Petitioner argues this suit is barred by the Eleventh Amendment because it was purportedly brought against Louisiana itself. (Pet. 7.) However, as both the trial court and the Court of Appeals noted, the body of respondents' complaint makes clear that the only defendant in the suit is the Attorney General of Louisiana, rendering this argument meritless. (Pet. 23a n.2 (citing

acting to enforce that law against respondents. Because the Louisiana statute is preempted by ERISA, the Attorney General's efforts to enforce it violated the Supremacy Clause. Respondents' action to enjoin the Attorney General from acting in violation of the Supremacy Clause falls precisely within the realm of actions permitted under *Ex parte Young*. As this Court stated in *Green v. Mansour*, 474 U.S. 64, 68 (1985), "the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause." Thus, contrary to petitioner's protestations, there was nothing "novel" in the Court of Appeals' application of *Ex parte Young* to this case, and there is no reason to review or reverse its decision.

Petitioner's reliance on *Seminole Tribe* is equally misplaced, since *Seminole Tribe* does not affect *Ex parte Young*'s application here. In *Seminole Tribe*, the Court held that Congress lacked the authority under the Indian Commerce Clause to abrogate Florida's Eleventh Amendment immunity to suit, 116 S. Ct. at 1131-32, an issue irrelevant to this case. In so holding, the Court stressed that it was not disturbing the traditional *Ex parte Young* cause of action, stating that "an individual can bring suit against a state officer in order to ensure that the officer's conduct is in compliance with federal law." *Id.* at 1131 n.14; *see also id.* at 1131 n.16.

While *Seminole Tribe* also held that Congress could not have intended to permit suits against state officials for

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Jones v. Louisiana ex rel. Bd. of Trustees, 764 F.2d 1183, 1185-86 (5th Cir. 1985)); Pet. 3 n.1.).

prospective relief where it had "prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right," *id.* at 1132, those circumstances are not present here. As the Court of Appeals noted, respondents do not seek to invoke any remedial scheme involving enforcement against a State. (Pet. 4a n.1.) Rather, respondents seek to prevent petitioner from violating the Supremacy Clause by encroaching on legal terrain that Congress has deemed exclusively the province of federal law.

In short, the decision of the Court of Appeals that the Eleventh Amendment does not bar this action is fully consistent with this Court's decisions, and there is no conflict in authority among the circuit courts requiring resolution by this Court. Accordingly, to the extent it seeks review of this question, the petition should be denied.[9]

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[9] In *Coeur D'Alene Tribe of Idaho v. Idaho*, 42 F.3d 1244 (9th Cir. 1994), *cert. granted*, 63 U.S.L.W. 3672 (U.S. Apr. 15, 1996) (No. 94-1474), a tribe sued to establish its purported right, under an Executive Order ratified by Congress, to land to which Idaho also claimed title. The Ninth Circuit held that the tribe could sue Idaho officials under *Ex parte Young* for relief establishing its rights to those lands. *Id.* at 1251-52. Even if this Court reversed that ruling, it would not alter the analysis in this case. Unlike *Coeur D'Alene*, this case involves efforts to enjoin a state official from violating the Supremacy Clause. Indeed, Idaho recognized in its brief that *Ex parte Young* applies to cases like this one, arguing that there (unlike here) "[t]he injunctive relief that the Tribe seeks is not tailored to enforcement of allegedly unconstitutional state statutes by state officers." Br. of Pet., No. 94-1474 at § (I)(c)(1) (filed May 30, 1996).

II. This Court Should Grant Certiorari on the ERISA Preemption Question

1. Section 514(a) of ERISA provides, with certain exceptions, that the provisions of ERISA

> shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

29 U.S.C. § 1114(a). One of the relevant exceptions is contained in ERISA § 514(b)(2)(A) which provides generally that the broad preemptive effect of § 514(a) shall not apply to "any law of any State which regulates insurance." This Court has construed both of these provisions many times, *see, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) ("relate to" clause) and *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (insurance "savings" clause), and most recently in its interpretation of the "relate to" clause in *Travelers*.

The question presented here, which has not previously been addressed by this Court, is whether, in light of *Travelers*, a state statute may, as Louisiana's any willing provider statute does, directly regulate the structure and administration of ERISA-covered employee benefit plans.[10]

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[10] Respondents recognize that this Court has pending before it another case involving ERISA's preemption provision. *See California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., Inc.* (No. 95-789), *cert. granted*, 64 U.S.L.W. 3689 (U.S. Apr. 15, 1996). The preemption issue in that case, however, arises in a far different context and may well be resolved on grounds that would not affect the analysis or result in this case.

The Court of Appeals faithfully followed this Court's decisions in holding that Louisiana's any willing provider statute was preempted because it "relate[s] to" ERISA-governed employee benefit plans and is not saved from preemption as a law "which regulates insurance." (Pet. 10a-11a, 15a.) Review by this Court is nonetheless warranted because of the national importance of the preemption question presented and the conflict and disarray among the lower courts over that issue.

2. Managed care programs such as those offered by respondents and affected by the Louisiana statute arose in response to marketplace demands from employee benefit plan sponsors for alternatives to indemnity programs that could control health care costs while assuring quality and access.[11] Generally speaking, managed care is a process by which the parties responsible for paying for health care services intervene in the health care delivery process in various ways in order to reduce the costs of such care and improve the quality of such care.[12]

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[11] *See* 1993 GAO Report at 2-6. HMOs and other managed care organizations have also been vigorously encouraged by both federal and state legislation. *See, e.g.*, Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e, *et seq.*; Health Maintenance Organization Act, N.Y. Pub. Health Law § 4400, *et seq.* (1995). *See also* 1993 GAO Report at 7 n.7 (discussing impact of legislation on the rapid growth of managed care); Douglas A. Hastings, *et al.*, eds., *Fundamentals of Health Law* 252 (1995).

[12] *Id.* at 245.

One popular method utilized by many insurers and other managed care organizations, including respondents, is to offer care through "preferred provider" panels or networks, referred to as PPOs.[13] PPOs selectively contract with physicians, hospitals, and others to obtain services for PPO participants at a discounted rate from normal charges. The preferred providers also agree to comply with various quality and utilization management requirements. In turn, the PPO will limit the size of its provider panel and will include incentives to its participants to encourage them to obtain care through the preferred provider panel. The expectation is that most participants will choose to utilize the provider network, resulting in a greater volume of patients for these providers. Increased patient volume, in turn, provides an incentive to the preferred providers to discount their fees. Similar networks are used to operate HMOs, in

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[13] Respondents offer a variety of health care coverages and administrative services to employee benefit plans. Respondent CIGNA Healthplan of Louisiana, Inc. is a licensed HMO that provides prepaid health care coverages to its subscribers through a network of selectively contracted medical providers, such as physicians. This provider network is offered to health care consumers both directly and through employee benefit plans, insurers, and other groups. (Pet. 6a.) Respondent Connecticut General Life Insurance Company is a licensed insurer that makes this network available to employee benefit plans, both on a fully insured basis and for use by self-funded or non-insured plans to which it provides administrative services. (*Id.*)

which the network is frequently the exclusive vehicle for obtaining prepaid care.[14]

Limiting the size of the provider network is key to its success. Providers are willing to discount their charges in light of the prospect of a high volume of referrals from the network and prompt payment from a single source. By limiting the number of providers, the network administrator is able to establish and monitor quality controls and to avoid the excess costs of dealing with an unlimited number of providers.[15] These quality and cost advantages directly

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[14] *Hastings, et al., Fundamentals of Health Law* at 245, 248; 1993 GAO Report at 6-10.

[15] *See* 1993 GAO Report at 9-10; Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 Ann. Health L. 71, 72 (1995) (discussing economics of provider panels); Bruce D. Platt, *Dispelling the Negative Myths of Managed Care*, 23 Fla. St. U.L. Rev. 489, 499 (1995) ("'Any Willing Provider' legislation defeats the entire concept of managed care"); Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 Ariz. St. L.J. 875, 915 (1995); Atkinson & Co., *Cost Impact of "Any Willing Provider" Legislation* (1994) (cost for a typical independent practice association would rise by forty-three percent under an any willing provider mandate); Wyatt Co., *Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* 3 (1991). The Federal Trade Commission has also recognized the detrimental effects of any willing provider laws on competition and has issued opinion letters urging states to discontinue laws that prohibit insurers from maintaining cost effective preferred provider arrangements. *See* Gary A. Francesconi, *ERISA Preemption of "Any*

benefit employee benefit plans that contract with the network to provide benefits to employees and their families. Depending on a plan's design, networks can provide either an exclusive or optional form of benefit delivery for an employee benefit plan, and network benefits can be provided through an insurance policy or an administrative-services-only basis to self-funded or non-insured plans.

As of 1992, the GAO found that over half of all private employers provided network-based managed care to their employees, covering 90 million persons.[16] Despite the growth and spread of network-based health care, the ability of respondents and their competitors to make high quality and low cost provider panels available to employee benefit plans is threatened by the proliferation of "any willing provider" statutes similar to the statute at issue in this action. Although the judgment in this case prevents enforcement of the Louisiana statute against respondents as applied to employee benefit plans, 25 other states have some type of any willing provider law on their books.[17] Therefore, al-

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Willing Provider" Laws -- An Essential Step Toward National Health Care Reform, 73 Wash. U. L.Q. 227, 262 n.159, 265 (1995) (collecting citations to FTC letters).

[16] *See* 1993 GAO Report at 5-7.

[17] *See* Ala. Code § 27-45-3 (Supp. 1994); Ark. Code Ann. § 23-79-114(b) (Michie Supp. 1993); Conn. Gen. Stat. Ann. § 38a-471 (West 1982); Del. Code Ann. tit. 18, § 7301 (Supp. 1994); Fla. Stat. Ann. § 408.706 (West Supp. 1995); Ga. Code Ann. §§ 33-20-16 (1976); Idaho Code § 41-3937 (Supp. 1995); 215 Ill. Comp. Stat. Ann. 5/370h (West 1993); Ind. Code Ann.

though respondents can now maintain limited provider networks in Louisiana, they or their affiliates in other states must still contend with similar laws in these states. States continue to enact any willing provider laws,[18] and both states and private parties continue to bring suit to enforce laws already on the books.[19] Indeed, prior to instituting

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§ 27-8-11-3(b)-(c) (Michie 1994); Ky. Rev. Stat. Ann. § 304.17A-110 (Banks-Baldwin Supp. 1994); 1994 Mass. Acts 60, §§ 148-49, 241; 1994 Minn. Laws 2927; Miss. Code Ann. § 41-83-3 (1994); N.H. Rev. Stat. Ann. § 420-B:12(V) (Supp. 1994); 1994 N.J. Laws SB 886/AB 1221; N.C. Gen. Stat. § 58-51-37 (1994); N.D. Cent. Code § 38.2-4209(B)-(D) (1994); Ohio Rev. Code Ann. § 1742.09(B)(2) (Anderson 1996); Okla. Stat. Ann. tit. 36, § 3634 (West Supp. 1994-95); S.D. Codified Laws § 58-18-37 (Michie 1990); Tex. Ins. Code Ann. art. 20A-14(g)(h) (West 1996); Utah Code Ann. § 31A-22-617 (1991); Va. Code Ann. § 38.2-3407 (Michie Supp. 1996); Wis. Stat. Ann. § 628.36 (West 1995); Wyo. Stat. Ann. § 26-22-503(a)(1) (Michie Supp. 1995). These do not include variations such as "price differential laws," which govern the difference in the allowable reimbursement for use of out-of-network services, and "due process laws," which mandate that health plans follow certain procedures in selecting and deselecting providers. *See Any Willing Provider Laws: Regulating the Health Care Provider's Contractual Relationship with the Insurance Company*, The Health Lawyer: The ABA Forum on Health Law 7 (1994-95).

[18] *See* Group Health Ass'n of America, *State Managed Care Legislative Resource* (1996).

[19] *See, e.g., American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc. and Prudential Ins. Co. of Am.*, No. 96-10084-MEL (D. Mass. filed Jan. 17, 1996) (suit by pharmacies alleging violation of Massachusetts any willing pharmacy law).

this action, respondents were sued by a physician under the Louisiana law and were threatened with actions by the petitioner Attorney General as well as by other private parties. (Pet. 7a.)[20]

3. Litigation over whether ERISA preempts any willing provider laws has produced divergent and conflicting results. At least one decision has, like the decision of the Court of Appeals in this case, held that ERISA preempts the state statute. *See Blue Cross and Blue Shield of Ala. v. Nielsen*, 917 F. Supp. 1532 (N.D. Ala. 1996). Others have held that the state statute was not preempted because it was saved as a law "which regulates insurance" even though it "relate[s] to" employee benefit plans. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019 (W.D. Tex. 1995). A recent decision from the Connecticut Supreme Court holds that causes of action to enforce a Connecticut statute that prohibits a provider network from excluding

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[20] Moreover, any willing provider statutes are merely illustrative of the proliferation of statutes regulating managed care practices that has occurred in the mid-1990s. States have recently enacted a multitude of provisions regulating the delivery of health care benefits which -- similar to any willing provider laws -- have the effect of mandating the structure of benefits provided by employee benefit plans. For example, "direct access" laws require closed-panel health plans to permit participants to bypass network gatekeeper requirements and access the services of certain specialists. "Freedom of choice" laws require closed-panel health plans to offer or reimburse out-of-network services.

willing providers based on criteria that have not been publicly filed are not preempted because they do not "relate to" employee benefit plans. *See Napoletano v. CIGNA HealthCare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996). Absent review and further guidance from this Court, employee benefit plans will be subject not to the uniform nationwide regulation mandated by ERISA, but to the patchwork of state regulation that ERISA's preemption provision was designed to prevent.

4. The Court of Appeals correctly determined that the Louisiana statute "relate[s] to" ERISA-covered employee benefit plans on two separate bases. Nonetheless, there is disagreement and conflict in the lower courts about the meaning and application of the "relate to" test after this Court's decision in *Travelers*.

a. The Court of Appeals correctly held that the Louisiana statute "relate[s] to" employee benefit plans because it directly refers to them and includes them within its regulatory ambit. As the Court of Appeals noted, the Louisiana statute specifically prohibits exclusion from the PPO of any "licensed provider...who agrees to the terms and conditions of the preferred provider contract." (Pet. 10a.) PPOs are defined in the statute as "contractual...agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment." La. Rev. Stat. Ann. § 40:2202(5)(a). A "group purchaser," in turn, is defined in language that directly encompasses employee benefit plans, as including:

> [e]ntities which contract for the benefit of their...employees, or members such as...Taft-

> Hartley trusts, or employers who establish or participate in self funded trusts or programs.

La. Rev. Stat. Ann. § 40:2202(3)(a). Employers or employee associations which contract to provide health care "for the benefit of their...employees or members" thereby establish "employee welfare benefit plans" subject to ERISA. *See* ERISA § 3(1), 29 U.S.C. § 1002(1); *see also Donovan v. Dillingham*, 688 F.2d 1367, 1371-73 (11th Cir. 1982). The Louisiana statute's application to ERISA plans is made even more explicit by its reference to "Taft-Hartley trusts"[21] as well as to "employers who establish...self funded trusts or programs." La. Rev. Stat. Ann. § 40:2202(3)(a). Given its express application to ERISA-covered employee benefit plans, the Louisiana statute "relate[s] to" such plans for preemption purposes "on that basis alone." *See District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 (1992).

b. The Court of Appeals also correctly held that the Louisiana statute "relate[s] to" ERISA plans because it prohibits an employee benefit plan from being structured to deliver benefits through a limited provider network. In reaching this conclusion, the Court of Appeals carefully considered the impact of this Court's decision in *Travelers*. In *Travelers*, this Court reviewed a New York statute that imposed surcharges on hospital bills payable through commercial insurance but not on bills payable by Blue Cross

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[21] *See NLRB v. Amax Coal Co., Div. of Amax, Inc.*, 453 U.S. 322, 334 (1981) (noting the applicability of ERISA to trust funds established to comply with the Taft-Hartley Act).

or Blue Shield. 115 S. Ct. at 1674-75. The Court held that the statute did not "relate to" employee benefit plans because it had only the "indirect economic effect" on the plans of raising the cost of commercial insurance and giving them an incentive to obtain coverage through Blue Cross. *Id.* at 1679. The Court noted that the New York statute merely "influenced a plan's shopping decision" but did not "mandat[e] employee benefit structures" or "bind plan administrators to any particular choice." *Id.* Recognizing, in contrast, that the Louisiana statute "specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner," the Court of Appeals correctly decided that the "limited *Travelers* holding...leaves undisturbed our conclusion that Louisiana's Any Willing Provider statute is preempted by ERISA." (Pet. 13a.)

5. A far different reading of *Travelers* has, however, been adopted by other courts. Nowhere is this conflict more evident than in a recent decision of the Connecticut Supreme Court that relied on *Travelers* to resolve the preemption issue adversely to respondents' Connecticut affiliate. *See Napoletano v. CIGNA HealthCare of Connecticut, Inc.*, 680 A.2d 127 (Conn. 1996). *Napoletano* (and a companion case addressed in the same opinion, *Hollis v. CIGNA HealthCare of Connecticut, Inc.*) involved a Connecticut statute, 1994 Conn. Pub. Acts 235, titled "An Act Concerning Managed Care." The Connecticut statute requires a preferred provider network to file with a state commission and make available to a provider "the general criteria for its selection or termination of health care providers" to the extent that such criteria are not proprietary or of a competitive nature. If the criteria have not been publicly filed, a network "may not

reject or terminate" a provider from participating in the network based on those criteria "until the provider has been informed of the criteria that his practice fails to meet." 680 A.2d at 131 n.3, quoting 1994 Conn. Pub. Acts 235(e)(2).

Plaintiffs in *Napoletano* sued one of respondents' Connecticut affiliates, a network administrator, alleging various statutory and common law causes of action, including an action for violation of the Connecticut managed care statute. *Id.* at 132. Reversing a trial court decision that these causes of action were preempted by ERISA, the Connecticut Supreme Court held that the claims were not preempted because they sought to "enforce," not modify, the terms of an employee benefit plan. *Id.* at 136.

In reaching this conclusion, the Connecticut Supreme Court extensively discussed this Court's opinion in *Travelers* which it characterized as having "indicated a retreat from preemption." *Id.* at 140 n.22. Citing to *Travelers*, the court reasoned that any "costs and burdens upon the benefit plans" were insufficient to trigger preemption because "the Supreme Court has concluded that indirect costs and benefits do not result in preemption." *Id.* at 143 n.26. Similarly, citing post-*Travelers* authority from federal courts of appeal, the court reasoned that "although a successful claim...under the Connecticut statute would in effect require that CIGNA continue to employ the plaintiff physicians, such a result would not have an impermissible or burdensome effect on the administration of the plan." *Id.* at 144.

The conflict in analysis between *Napoletano* and the Court of Appeals' decision in this case goes beyond their disagreement over whether *Travelers* was intended by this

Court to "indicate[ ] a retreat from preemption." The Court of Appeals in this case held that the State of Louisiana simply could not permissibly regulate employee benefit plans and their administration. The Connecticut Supreme Court, in contrast, concluded that *Travelers* has sufficiently changed the preemption landscape that it is permissible for a state to regulate a plan's administration as long as that regulation is not, in a court's view, "burdensome." *Id.* The two analyses cannot be reconciled. Rather, they squarely conflict over whether, after *Travelers*, state regulation may directly regulate plan structure and administration.

7. The conflict in the preemption analysis among the lower courts is not limited to the "relate to" prong of ERISA § 514(a) but extends also to whether, or under what test, an any willing provider law may be "saved" from preemption under ERISA § 514(b)(2)(A) as a law "which regulates insurance." While the Court of Appeals in this case held that the Louisiana statute was not saved on this basis, the Court of Appeals for the Fourth Circuit reached the opposite result in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993), as to Virginia's any willing provider statute. Similarly, a district court in the Fifth Circuit has followed the Fourth Circuit's decision to hold that a Texas statute applicable to pharmacies was saved as a law "which regulates insurance." *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019 (W.D. Tex. 1995).

These decisions conflict in the way they analyze ERISA's insurance saving clause. This Court has held that a determination of whether a state law "regulates insurance"

for purposes of ERISA preemption should be made by considering a "common-sense" definition of insurance regulation plus an analysis of the three factors used to determine what constitutes "the business of insurance" under the McCarran-Ferguson Act. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987). The court below -- following its own precedent that a law is not saved from ERISA preemption unless it satisfies both the common-sense definition of insurance regulation and each of the three McCarran-Ferguson factors -- found it unnecessary to analyze anything other than the third factor since the Louisiana statute "obviously is not limited to entities within the insurance industry." (Pet. 14a & n.51, *quoting Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993).) The Court of Appeals for the Fourth Circuit in *Stuart Circle*, however -- following its precedent that none of these factors is determinative -- reached the opposite result. Because decisions in the circuits are in conflict over how to analyze ERISA's insurance savings clause,[22] review by this Court is appropriate to resolve this conflict also.

8. Review by this Court is especially urgent because of the widespread use of managed care by ERISA-covered employee benefit plans throughout the country. Unless the

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[22] *Compare DeBruyne v. Equitable Life Assur. Soc. of the U.S.*, 920 F.2d 457, 468-70 (7th Cir. 1990) (requiring each factor to be met) *with Insurance Bd. Under Soc. Ins. Plan of Bethlehem Steel Corp v. Muir*, 819 F.2d 408, 411 & n.5 (3d Cir. 1987); *United Food & Comm. Workers & Employers Az. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986) (holding that no one factor is dispositive).

preemption question presented here is resolved by this Court, employee benefit plans will be faced with the prospect of either litigating over this preemption issue in multiple jurisdictions or simply foregoing implementation of managed care features such as limited provider networks, especially on a uniform nationwide basis. This case presents a clearcut example of a state statute that interferes with the design and administration of employee benefit plans and an undisputed factual record on which the preemption issue can be resolved. Accordingly, respondents urge the Court to grant the petition as to this issue and resolve this issue without waiting for the conflict in the lower courts to continue to fester.

CONCLUSION

For the foregoing reasons, this Court should grant the petition limited to the first question presented involving ERISA preemption.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

State of Louisiana ex rel. RICHARD P. IEYOUB,
Attorney General,
Petitioner,

v.

CIGNA HEALTHPLAN OF LOUISIANA, INC., and
CONNECTICUT GENERAL LIFE INSURANCE CO.,
Respondents.

On Petition For A Writ of Certiorari
To The United States Court of Appeals
For The Fifth Circuit

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF MANUFACTURERS AND AETNA INC.

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IN THE
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BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF MANUFACTURERS AND AETNA INC.

INTEREST OF *AMICI CURIAE*

Amicus the National Association of Manufacturers ("NAM") is the nation's oldest and largest broad-based industrial trade association. Its more than 14,000 member companies and subsidiaries, including approximately 10,000 small manufacturers, are located in every State and produce roughly 85 percent of U.S. manufactured goods. Through its member companies and affiliated associations, NAM represents every industrial sector, 185,000 businesses and more than 18 million employees. The overwhelming majority of NAM member companies sponsor health benefit programs for their employees, and most of these programs use some form of managed care.

Aetna Inc., through its health-related subsidiaries, is one of the Nation's largest administrators of managed health care programs. Aetna has created and maintains managed care networks, including preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs"), in Louisiana and throughout the country. Aetna provides structured health care programs and administrative services to thousands of employers, representing approximately 16 million managed care members nationwide. In Louisiana, more than 100,000 individuals receive treatment through an Aetna-administered managed care program, including more than 40,000 in Aetna PPOs and almost 35,000 in HMOs.

As employee benefit plan sponsors and administrators, *amici* have a vital interest in maintaining cost-effective quality health care for plan participants. Managed care is critical to achieving this goal. Statutes like LA. REV. STAT. § 40:2202(5)(c), the Louisiana any willing provider law at issue in this case, undermine the fundamental principles of managed care by constricting the ability of plan administrators to control managed-care networks. As a result, enforcement of such laws in other States imposes damaging constraints on employee benefit plans, directly contrary to the purpose of ERISA, which was intended to free employee benefit plans from the often stifling and costly restrictions imposed by widely varying and inconsistent state regulation. The parties have consented to the filing of this *amicus* brief.

DISCUSSION

This case presents the question whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts so-called "any willing provider" laws that prevent preferred provider organizations ("PPOs") and similar

managed-care networks from limiting the number of health care providers that are members of such organizations. That question has divided the state and federal appellate courts, with the result that ERISA plan providers and administrators are being subjected to conflicting requirements and inconsistent degrees of federal protection in different jurisdictions across the country.

Moreover, the question presented in this case is of extraordinary importance for the economically efficient delivery of health care to employee benefit plan participants across the Nation. The Louisiana any willing provider law at issue in this case (LA. REV. STAT. § 40:2202(5)(c)), like similar statutes in other States across the country, severely restricts the ability of employee benefit plan administrators to control provider membership in managed-care networks. In so doing, these statutes undermine the fundamental economic logic of managed-care arrangements and threaten to destroy the promise of managed health care to achieve widely available cost-effective medical treatment. In short, these statutes subject employee benefit plans to precisely the kind of inconsistent and inefficient regulation that ERISA was intended to preempt.

Absent plenary review by this Court, low-cost and innovative health care options will continue to be stifled on a haphazard basis in many States as the lower courts continue to reach inconsistent results on the question whether ERISA preempts any willing provider laws. *Amici* urge the Court to grant plenary review of the petition's first question in order to ensure a consistent nationwide solution to this important and pressing question.[1]

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[1] The second question presented in the petition is not worthy of review. Petitioner does not and cannot contend that

I. THIS CASE PRESENTS AN IMPORTANT FEDERAL QUESTION THAT SHOULD BE RESOLVED BY THIS COURT

The efficient delivery of health care is an intractable problem; solutions will require ingenuity, experimentation, and flexibility. ERISA encourages these solutions through its broad preemption provision, which is intended to relieve employee benefit plans of the burden of compliance with state regulation. *E.g.*, *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1677 (1995); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Among other things, ERISA precludes any state regulation that interferes with attempts to provide efficient delivery of health care to employee benefit plan participants. Any willing provider laws fall squarely into this category.

ERISA preemption establishes employee benefit plan regulation "as an area of exclusive federal con-

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the second question involves a circuit conflict, and the court of appeals' ruling on that issue is wholly consistent with, and indeed compelled by, binding precedent of this Court. *E.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983). This Court's decision in *Seminole Tribe of Fla. v. Florida*, 116 S. Ct. 1114 (1996), is not to the contrary. That decision holds only that injunctive relief is inappropriate "where Congress has prescribed a *detailed remedial scheme* for the enforcement against a State of a *statutorily* created right." 116 S. Ct. at 1132 (emphasis added). No such detailed scheme exists here, and respondents sought enforcement of the Supremacy Clause, not merely a statutory right. Moreover, *Seminole Tribe* expressly reaffirms that litigants "may obtain injunctive relief under *Ex parte Young* in order to remedy a state officer's ongoing violation of federal law." *Id.* at 1131 n.16; *see also id.* at 1133 n.17.

cern." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). ERISA preempts not only state laws on subject matters covered by ERISA, but also all state laws that have any "connection with or reference to" an employee benefit plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983); *Travelers*, 115 S. Ct. at 1677. ERISA occupies the field; where ERISA does not regulate a certain aspect of employee benefits, the area is to be free from regulation under both ERISA and state law. *Shaw*, 463 U.S. at 98-99. The resulting "regulatory void" in certain areas evinces congressional intent to leave those subjects to the discretion of benefit plan designers and labor-management negotiations. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

Health care is one such area. ERISA places few restrictions on the delivery of employee welfare benefits, like health care, allowing instead for broad-ranging innovation and ready adaptation to changing circumstances. *See* 29 U.S.C. § 1051(1) (exempting welfare plans from participation and vesting requirements applicable to pension plans); 29 U.S.C. § 1081(1) (exempting welfare plans from funding requirements applicable to pension plans). "[M]edical insurance must take account of inflation, changes in medical practice technology, and increases in the cost of treatment independent of inflation." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). ERISA leaves health care plan administrators free to do just that.

Any willing provider laws like the statute at issue in this case effectively tie the hands of plan administrators and threaten to preclude employee benefit plans from offering health benefits through PPOs. These managed-care arrangements are precisely the type of market-driven innovation that Congress intended to encourage through enactment of ERISA. *See Moore v.*

Reynolds Metals Co. Retirement Program, 740 F.2d 454, 456 (6th Cir. 1984) ("decisions [concerning plan benefits] are more appropriately influenced by forces in the marketplace and, when appropriate, by federal legislation"), *cert. denied*, 469 U.S. 1109 (1985). The destructive effects of any willing provider laws on PPOs underscore the extraordinary importance of this case to the efficient delivery of health care.

The PPO is a mechanism by which employee benefit plans deliver health care to plan participants at reduced cost. The cost savings afforded by a PPO are made possible by ensuring increased patient volume for preferred providers. PPO administrators customarily contract with a limited network of "preferred" health care providers for the provision of health care services to employee benefit plan participants. Employee benefit plan participants who choose PPOs are given financial incentives to use preferred rather than nonpreferred providers; participants typically are reimbursed for a greater percentage of the cost of treatment by a preferred provider. This practice results in a relatively greater number of patients for preferred providers. Increased patient volume allows the preferred providers to lower their per-patient costs, which, in turn, permits the providers to discount their fees. The promise of increased patient volume also creates price competition among providers, to the benefit of plan participants. *See, e.g.*, Lori A. Tobias, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A "Green Light to the Gold Rush"?*, 41 SW. L.J. 1155, 1187-1190 (1988); G.A. Melnick, *et al.*, *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217 (1992).

Some limitation on PPO provider membership is thus necessary to enable the preferred providers to receive an increase in patient volume sufficient to warrant the reduction in fees. *HCA Health Services of*

Virginia, Inc. v. Metropolitan Life Ins. Co., 752 F. Supp. 202, 204 (E.D.Va. 1990) ("The exclusion of some providers is a necessary prerequisite of a limited provider network. It is by limiting the number and types of providers included in a PPO that a [PPO administrator] is able to implement cost reductions in services for health beneficiaries."), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992). The broader the PPO network, the less likely it is that the preferred providers will each experience the increase in patient volume necessary to permit cost reductions.

Limited provider networks are beneficial in other ways as well. PPO administrators can lower costs and improve the quality of medical care by eliminating unnecessary treatment. Pre-utilization review, monitoring of provider practices, and provider education all make health care utilization more effective and efficient. But it becomes more difficult and expensive for plan administrators to provide such service to plan participants as the number of providers in the network increases. General administrative expenses associated with the processing and payment of claims also increase as plan administrators must deal with more providers. *See* John F. Sheils, David C. Stapleton & Randall A. Haught, THE COST OF LEGISLATIVE RESTRICTIONS ON CONTRACTING PRACTICES: THE COST TO GOVERNMENTS, EMPLOYERS AND FAMILIES 3-4, 14-15 (Lewin-VHI 1995). A limited PPO network means more savings and better health care for plan participants.

The cost savings made possible by the PPO option are substantial. A recent study of employee health plan data found that health spending for participants in PPO plans was about 11 percent less than in traditional fee-for-service plans due to a combination of price discounts and utilization controls. David C. Stapleton, NEW EVIDENCE ON SAVINGS FROM NETWORK MODELS

OF MANAGED CARE 4 (Lewin-VHI 1994). The Congressional Budget Office has reported that national spending for health care grew about 6 percent in 1994, the slowest rate in 30 years, in part due to a dramatic increase in managed care programs, including PPOs and health maintenance organizations ("HMOs"). Congressional Budget Office, THE ECONOMIC AND BUDGET OUTLOOK: AN UPDATE 82-83 (1995).

Any willing provider laws undermine these salutary effects by mandating the unlimited expansion of PPO provider membership. These laws therefore increase dramatically both the cost of administration and the cost of claims made by employee benefit plan participants. One recent study concluded that if a national any willing provider law had been enacted in 1995, it would have increased private sector health spending by almost $75 billion through the year 2002. THE COST OF LEGISLATIVE RESTRICTIONS ON CONTRACTING PRACTICES at 25. It is not surprising that a 1986 survey of PPO sponsors found that mandatory provider statutes -- a variant of any willing provider laws -- posed the most serious of all possible regulatory threats to the effective operation of PPOs. Elizabeth S. Rolph, Paul B. Ginsburg & Susan D. Hosek, *The Regulation of Preferred Provider Organizations*, 6 HEALTH AFFAIRS 32, 40 (Fall, 1987).[2]

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[2] Any willing provider laws pose the same threat to HMOs, another form of managed care. HMOs contract with participating health care providers in a number of ways -- including independent contracting with individual physicians, contracting with medical group practices or associations of physicians, or direct employment of physicians -- but the fundamental economic logic of the HMO, and the basis for the substantial savings it generates, are the same as those of a PPO: each benefits from a limited provider network. To varying extents, HMOs differ from PPOs in that the purchaser of medical services from an HMO, typically a benefit plan

These increased costs will be felt by plan participants in the form of higher deductibles and copayments, and by plan sponsors who foot most of the bill for employee health care. This burden only adds to the strain that escalating employee health care liability already imposes on employers. By exacerbating the health care crisis, any willing provider legislation imposes a significant drag on the economy.

The federal government has recognized that any willing provider laws also impair competition among health care providers, to the detriment of consumers. The Federal Trade Commission has for over a decade objected to mandatory provider laws as anticompetitive and anticonsumer. Attached (App., *infra*, 1a-10a) is a 1993 letter from the Acting Director of the FTC's Office of Consumer and Competition Advocacy to the Attorney General of the State of Montana. The letter details the FTC's objections to Montana's any willing provider statute, reaffirming all of the cost and competition effects discussed above. The Acting Director explains the competitive importance of limited-provider

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sponsor, generally pays on a capitated basis (*i.e.*, the sponsor pays a fixed fee to the HMO for each participant in the plan), rather than on the discounted fee-for-service basis that is the norm for PPOs. Another important distinction is that the HMO network is usually exclusive: plan participants enrolled in an HMO must use an in-network provider if they are to receive any benefits at all. This obviously creates powerful incentives for all participants to use HMO providers, and increases the HMO administrator's ability to extract price discounts from competing health care providers seeking the HMO business. In addition, all of the utilization control and administrative cost savings associated with limited PPO networks apply to limited HMO networks as well. To the extent any willing provider laws can be read to apply to HMOs, their destructive effects are multiplied.

panels and the anticompetitive, anticonsumer effect of any willing provider requirements. The letter also describes the FTC's long-standing public objection -- expressed through congressional testimony, comment letters to state legislators and agencies, and litigation[3] -- to efforts to suppress selective contracting with a limited panel of health care providers. The FTC's opposition to any willing provider laws underscores the importance of the issue in this case to health care consumers.

Any willing provider laws unduly restrict the ability of employee benefit plan administrators to construct health care arrangements for the benefit of plan participants. The Louisiana statute at issue in this case, for example, precludes flexibility in plan structure and instead imposes a particular mechanism for provider selection, whereby a plan administrator first must establish a set of "terms and conditions" for network participation. LA. REV. STAT. § 40:2202(5)(c). Left to its own judgment, however, a managed care plan might choose not to establish a uniform set of terms and conditions for network participation. Indeed, it is probably more efficient not to do so. A plan administrator often can achieve better service and lower cost by negotiating with providers or groups of providers on an ad hoc basis. By pitting health care providers

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[3] The FTC has instituted a series of law enforcement actions to prevent private anti-competitive arrangements that suppress or eliminate selective contracting. *See, e.g., Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988). *See generally* App., *infra*, 2a-3a. These private arrangements have the same deleterious effects as any willing provider laws.

against one another in market-driven competition for plan business, a plan administrator can often extract price discounts. *See Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc.*, 784 F.2d 1325, 1343 (7th Cir. 1986) (requiring plans to offer the same price to all providers "would make hash of the idea of a PPO. . . . The requirement that [providers] bid in order to get the plan's business is the principal source of the incentive to cut costs, and the prospect of getting more business by becoming a 'preferred' provider is the principal benefit to the [provider].").

Moreover, providers differ widely in the package of goods they can offer plan participants, including range of services, quality of care, geographic access, and general availability. A prudent plan administrator will consider all these factors in deciding whether, and under what conditions, to include a provider or group of providers in a PPO network. *See* THE COST OF LEGISLATIVE RESTRICTIONS ON CONTRACTING PRACTICES at 18.

While the decision below properly holds that any willing provider laws are preempted, and thereby avoids the deleterious effects discussed above, the Fifth Circuit's ruling is binding in only three States. Unfortunately, any willing provider laws and analogous statutes have been adopted in numerous States across the country.[4] Absent review by this Court, many of those

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[4] The Louisiana any willing provider law is part of an alarming recent trend toward mandatory-provider legislation. Several States impose a requirement that any provider willing to meet the terms and conditions of a PPO must be allowed into the network. *E.g.*, GA. CODE ANN. § 33-20-16; 215 ILL. COMP. STAT. ANN. § 5/370h; IND. CODE ANN. § 27-8-11-3; VA. CODE §§ 38.2-3407, 38.2-4209; WYO. STAT. § 26-22-503; *see also* UTAH CODE ANN. § 31A-22-617. The any willing provider requirements in some States apply to all health

laws will continue to hinder the ability of ERISA plan administrators to offer low-cost managed health care options to plan beneficiaries and will thwart Congress's intent to foster innovation and flexibility in the provision of employee benefits. Accordingly, the question presented in this case is one of exceptional importance, and review by this Court is necessary.

II. THE COURT OF APPEALS' DECISION IS INCONSISTENT WITH THE DECISIONS OF OTHER STATE AND FEDERAL APPELLATE COURTS

Section 514(a) of ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). Under ERISA Section 514(b)(2)(A), however, "any law of any State which regulates insurance" is saved from preemption. 29 U.S.C. § 1144(b)(2)(A). For purposes of applying this insurance savings clause, the statute makes clear

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care providers, while in other States the law excludes institutional providers. *E.g.*, 215 ILL. COMP. STAT. ANN. 5/370h; LA. REV. STAT. ANN. § 40:2202(5)(c). In still other States, the law applies only to pharmacy arrangements. E.g., ALA. CODE § 27-45-3; IDAHO CODE § 41-1844; S.D. CODIFIED LAWS ANN. § 58-18-37; TEX. INS. CODE, art. 21.52B. And numerous States mandate inclusion of certain types of providers (*e.g.*, chiropractors or podiatrists). *E.g.*, KAN. STAT. ANN. §§ 40-2,100, 40-2,101; MO. REV. STAT. §§ 354.027, 375.936(11)(b); NEB. REV. STAT. § 44-4112; NEV. REV. STAT. ANN. §§ 695C.177, 695C.178; W.VA. CODE § 33-25A-31. Overlaid on these disparate statutory requirements are regulations in the various States that may impose additional requirements or otherwise give specific meaning to the often indeterminate language of statutes. *E.g.*, Ark. Ins. Comm. Bulletin 9-85 & 9-85A (1985) (interpreting Arkansas statute as an any willing provider law).

that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance." ERISA §514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

In this case, the court of appeals correctly held that a State's attempt to impose an any willing provider requirement on entities establishing or offering PPO networks "relate[s] to" employee benefit plans and is not saved from preemption by the insurance exception. By contrast, a number of other appellate courts have reached the opposite result in the same or similar contexts. As the law currently stands, therefore, benefit plan administrators face burdensome any willing provider requirements in some jurisdictions, yet are immune from precisely those same requirements in other jurisdictions. This clear conflict in the scope of ERISA preemption merits plenary review.

At least one appellate court has issued a decision that conflicts with the court of appeals' correct determination that statutes regulating PPO membership "relate to" employee benefit plans for purposes of ERISA preemption. In *Napoletano v. CIGNA Healthcare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996), the Supreme Court of Connecticut held that the State's managed care statute did not "relate to" employee benefit plans and was therefore not subject to ERISA preemption. *Id.* at 136-45. The court reached this conclusion despite the fact that the Connecticut statute requires PPO networks to file with the State their criteria for selecting health care providers, and then grants health care providers and ERISA plan participants the right to sue over the exclusion of providers from the networks. *Id.* at 130 n.3, 144-45, 146.

This holding, and the reasoning supporting it, are directly inconsistent with the decision of the court of appeals in this case. The *Napoletano* court based its narrow reading of the "relate to" clause on *New York*

State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1996), which (according to the *Napoletano* court) mandates a "retreat[] from" this Court's previously expansive view of ERISA preemption. 680 A.2d at 140. The court below, by contrast, relied on "the limited nature of [the] holding" in *Travelers* to conclude that statutes regulating the membership of ERISA plans' PPO networks necessarily "relate to" those plans within the meaning of ERISA's preemption provision. Pet. App. 13a.

As a result of this disagreement over the scope of the *Travelers* decision, these courts reached diammetrically opposed results on the question whether a state law "relate[s] to" ERISA plans if it purports to regulate the ability of PPOs offered by ERISA plans to exclude health care providers from their networks. *See also Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir.) (holding that an any willing provider law "relate[s] to" employee benefit plans), *cert. denied*, 510 U.S. 1003 (1993). This conflict over the meaning of "relate to" and the impact of this Court's *Travelers* decision by itself warrants certiorari review.

In addition, several appellate courts have incorrectly held (in contrast to the decision below) that any willing provider statutes or analogous state laws are saved from ERISA preemption by virtue of ERISA's insurance savings clause. In *Stuart Circle Hosp. Corp.*, *supra*, for example, the Fourth Circuit upheld a Virginia statute that requires insurers (including insurers acting as third-party administrators of employee benefit plans rather than as providers of traditional health insurance) to admit all willing providers to their PPO networks. 995 F.2d at 502-04. The court conceded that this any willing provider statute "relates to" employee benefit plans and that "facially the statute only directly affects providers" rather than insureds, but

nonetheless held that the statute was saved from preemption as "a law regulating the business of insurance." 995 F.2d at 502, 504.

Similarly, the Tenth Circuit in *Blue Cross & Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986), rejected an ERISA preemption challenge to a Kansas "mandated-provider" statute. The Kansas statute required employee benefit plans offering health insurance benefits to cover services provided by all members of a specified class of health care providers. *Id.* at 1333. The court held that the mandated-provider law regulated "the business of insurance" and was therefore not preempted (*id.* at 1334-36), even though the effect of the statute was to expand the ability of health care providers (who are plainly *not* engaged in "the business of insurance") to receive reimbursement from employee benefit plans.

In *Blue Cross & Blue Shield of Va. v. St. Mary's Hosp. of Richmond, Inc.*, 426 S.E.2d 117 (Va. 1993), the Virginia Supreme Court addressed an ERISA preemption challenge to an any willing provider statute that applied to PPOs offered by nonstock corporations. *Id.* at 118. Applying what it characterized as the "common-sense" approach articulated by this Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Virginia court concluded that this any willing provider law "'regulates insurance' within the meaning of ERISA's exception to its preemption clause." 426 S.E.2d at 122. Accordingly, the court held that the statute was not preempted by ERISA. *Id.* Other cases are to the same effect. *See, e.g., Blue Cross Hosp. Serv., Inc. v. Frappier*, 698 S.W.2d 326, 327 (Mo. 1985) (rejecting ERISA preemption challenge to mandated-provider statute based on the insurance savings clause); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019 (W.D.

Tex. 1995) (holding that any willing provider statute is covered by ERISA's insurance savings clause).

Absent review by this Court, therefore, ERISA plan sponsors and administrators such as respondents and *amici* will continue to be faced with a patchwork of inconsistent state and federal law. In some States, ERISA's broad preemption provision will preclude enforcement of any willing provider statutes against managed-care networks serving employee benefit plans. In other States, by contrast, laws that impose precisely the same regulatory burden on managed-care networks will be immunized from challenge under ERISA, and benefit-plan administrators will therefore be unable to obtain the full benefits of managed care for their plan participants. This Court's review is necessary to eliminate these conflicts and achieve nationwide consistency in the scope of ERISA preemption.

CONCLUSION

With respect to the first question presented, the petition for a writ of certiorari should be granted. In all other respects, the petition should be denied.

Respectfully submitted.

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September 30, 1996

APPENDIX

APPENDIX

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, Montana 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for view on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has

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[2] 15 U.S.C. § 41 *et seq.*

[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider

taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these comments have

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Health Care Act of 1983 at 2-3 (October 24, 1983); *Health Care Management Associates*, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). *See also* Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effect on Competition (1977).

[4] *See, e.g., Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d. 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982); *Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979); *Medical Staff of Doctors' Hospital of Prince George's County*, 110 F.T.C. 476 (1988); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988); *Medical Staff of Holy Cross Hospital*, No. C-3345 (consent order, Sept. 10, 1991); *Medical Staff of Broward General Medical Center*, No. C-3344 (consent order, Sept. 10, 1991); *see also American Society of Anesthesiologists*, 93 F.T.C. 101 (1979); *Sherman A. Hope, M.D.*, 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. *See e.g.*, Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

addressed "any willing provider" requirements for health care service contracts.[6]

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met

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[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action, the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how providers and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may pro-

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[8] Mont. Code Ann., § 33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

[9] Mont. Code Ann. § 33-22-1704(3).

vide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10] In addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not,

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[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. *See*, e.g., J.C. Robinson and C.S. Phibbs, *An Evaluation of Medicaid Selective Contracting in California,* 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience; however, further studies based on private health insurance experiences conf irm these findings. *See e.g.*, D. Dranove et al., *Is hospital competition wasteful?* Rand J. Econ., Summer 1992; *see also* G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would

help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both cost and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can

expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without provided any additional consumer benefit.

V. Conclusion.

In summary, we believe that "any willing provider" requirement may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health

care programs, without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

/s/ Michael O. Wise
Michael O. Wise
Acting Director